

# NAHQRS

Nebraska Association for Healthcare  
Quality, Risk, & Safety



Nebraska Association for Healthcare  
Quality, Risk and Safety

<http://www.nahqrs.org/>

**Volume 2**  
**Issue 2**



**Kathi Kelly, RN, BSN, CPHQ**  
**President, NAHQRS**  
**Director of Quality Programs, Risk Manager,**  
**Privacy Officer**  
**Memorial Health Care Systems**  
**Seward, Nebraska**

Have you noticed the subtle signs of spring; early morning bird songs, flowers popping up, warmer weather, and the wonderful gift of longer days? As we joyfully embrace spring, we are ignited with enthusiasm for dusting off those old projects to be completed – right? NAHQRS is a wonderful venue for making connections with peers who can give you a helping hand with those projects by sharing knowledge, policies and procedures, and innovative tools.

Thank you to Brad Lindblad for hosting our fabulous February meeting at Mary Lanning Memorial Hospital. I am sure that we all benefited from the fall prevention presentation. What a great day! It was also a productive day, working together to develop NAHQRS Mission Statement. Thank you for your valuable input. It is a work in progress and you will have the opportunity to review the revised proposed mission statements at our April meeting.

Many members are helping with the NAHQRS Vendor Show that will be held during the CIMRO Quality Forum on May 4<sup>th</sup> at the Embassy Suites in Lincoln. If you have a vendor that would like to participate, please contact Kari Clark 402-564-1859.

Delinda Lampe accepted the position as our Event Coordinator – thank you! Delinda recruited Pat Hoidal to assist her and together they will further define this position. Delinda has already made reservations for our December 5<sup>th</sup> meeting at Chances R.

The economy presents us with challenges and opportunities. Nebraska is fortunate to have patient focused organizations willing to merge together with the goal of improving patient safety and care. Together we can make a difference!

It continues to be an exciting time to see the progress of NAHQRS as we achieve our strategic goals. I invite you to contact me with any concerns and recommendations you have for our organization. I look forward to seeing you at the April meeting.

**Kathi**

## 2009 List of Officers and Board Members

### **President**

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Nebraska Association for Healthcare  
Quality, Risk and Safety

## Board Members

### **Historian**

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## Historian Report

No report this Newsletter

*Donna Jorgensen*

### Reminder:

Please send me your application and dues (\$50) for 2009 if you have not already done so.

Thank you!

Cathy Broz, RN, BSN  
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## NAHQRS Member Bio

No Member Bio's this Newsletter

**"If you can't find God in the next person you meet, then you are wasting your time trying to find Him at all."**

**Mahatma Gandhi**



## The Nebraska Coalition for Patient Safety: An Update

During 2008, the Coalition began to receive information from member hospitals about patient safety events that occurred in their facilities. The Nebraska Coalition for Patient Safety (NCPS) member hospitals are asked to provide information on patient safety events that resulted in serious harm, including death, to the patient, and are encouraged to report other events that, while they may not have caused harm to the patient, have educational value.

When an event occurs, the hospital completes a root cause analysis (RCA) to identify the systems issues (causal statements) that contributed to the event. These issues are grouped into broad categories of causal statements such as environment/equipment issues; human factors/communication; human factors/training; human factors/fatigue/scheduling; organizational factors; patient management factors; patient/family factors; and rules/policies/procedures. Hospitals also develop and share their action plan to resolve the systems issues they identified.

Based on the information shared with the Coalition, a monthly Patient Safety Report is written and distributed to NCPS member hospitals. The Patient Safety Report summarizes one of the events and provides a list of resources pertinent to the issues involved in the event. Hospitals use the Patient Safety Reports to assess their risk, review their processes and identify systems which might need modification.

The NCPS sponsored two workshops on conducting a root cause analysis during 2008. A total of 73 individuals, representing 33 hospitals participated in the day-long, hands-on workshops. Since reporting is the foundation of learning in a culture of safety, the RCA is an important tool to identify the issues surrounding a patient safety event. The NCPS plans to hold its first educational conference on August 18, 2009. David Marx, *The Just Culture*, will be our keynote speaker. The afternoon will consist of four concurrent breakout sessions; each session will be repeated a second time, so that attendees may participate in two of the four sessions.

If you have any questions about the Nebraska Coalition for Patient Safety, please contact Monica Seeland at [mseeland@nhanet.org](mailto:mseeland@nhanet.org).

Monica Seeland, RHIA  
Vice President Quality Initiatives  
Nebraska Hospital Association



Resources for better healthcare

## **CareTrek™, A CIMRO of Nebraska Care Transitions Project**

Submitted by Janet Dooley, RHIA, CPHQ, Director of Medicare Operations

Through a competitive procurement, CIMRO of Nebraska was awarded one of 14 nationally by the Centers for Medicare & Medicaid Services to conduct a cutting-edge initiative to improve care transitions between healthcare settings. CIMRO of Nebraska's local project, CareTrek, is being conducted in the Omaha metropolitan area (Douglas and Sarpy counties). Over 100 healthcare providers and community stakeholders gathered to support and demonstrate commitment for the project at the CareTrek launch in late January.

CareTrek efforts will focus on the following:

- Hospital and community system-wide interventions
- Interventions that target specific diseases or conditions
- Interventions that target specific reasons for readmission

Transitional care is defined as a set of actions designed to ensure the coordination and continuity of healthcare as patients transfer between different locations and/or levels of care in the same location. When the process is not coordinated properly, the beneficiary is left in a vulnerable state and at an increased risk of re-hospitalization. In addition, the costs to Medicare for these potentially avoidable re-hospitalizations are significant.

Approximately 19,000 Medicare beneficiaries are admitted each year to hospitals in Douglas and Sarpy counties; of those, nearly one in six are re-hospitalized within 30 days.<sup>1</sup> Medicare patients report greater dissatisfaction related to discharge than to any other aspect of care measured by CMS. A Medicare Payment Advisory Commission study found that 75 percent of all 30-day hospital readmissions of Medicare patients in 2005 were potentially preventable. A two percent reduction in readmissions in the Omaha metropolitan area alone would save over three million dollars per year. These staggering statistics indicate there is a considerable amount of room for improvement and incentives for change.

CIMRO of Nebraska, a leader in care transitions, understands CareTrek requires a multidisciplinary and multi-provider effort. CareTrek is bringing together appropriate healthcare providers, stakeholders and community organizations to develop and implement an evolving intervention plan to reduce re-hospitalization among Medicare beneficiaries residing within Douglas and Sarpy counties. With hospitals as the drivers of change, the goal is to implement sustainable care models to reduce unnecessary hospital readmissions by addressing patient medication management, patient self-management, post-discharge follow-up and plans of care for patients who move across healthcare settings.

CIMRO of Nebraska is accountable for ongoing project management and facilitation of CareTrek. CIMRO of Nebraska will assist providers and the community in creating resources for more effective transitions and in implementing improvement activities beyond the period of hospital discharge. Workflow analysis, data, tools and technical assistance will also be provided to CareTrek participants.

The long-term impact of the CareTrek initiative and similar projects across the country have the potential to significantly improve healthcare, including lives and dollars saved. CIMRO of Nebraska will share CareTrek successes and lessons learned with Nebraska healthcare professionals to spread change and best practices for continued quality improvement. For more information about CareTrek and care transitions, visit CIMRO of Nebraska's Web site at: <http://www.cimronebraska.org/CareTrek.aspx>.

1 Source: Medicare claims data

This material was developed by CIMRO of Nebraska, the Medicare Quality Improvement Organization for the state of Nebraska, under contract with the Centers for Medicare & Medicaid Services (CMS), a federal agency of the U.S. Department of Health and Human Services. The contents presented do not necessarily reflect CMS policy. 9SOW-NE-CT-21/0209

**Have a new Job?**

**Get a new phone number?**

**Change your email address?**

**Forgot to tell your best friends?**

**If you have changes that we should know about – just click on the link below to forward those changes to the people who really care.**

**Cathy Broz**

[dchqi@bwtelcom.net](mailto:dchqi@bwtelcom.net)

## **Quality – Risk Management – Patient Safety**

### **Validation is Key to Effective Hourly Rounding**

"But we're already doing it!"

### **Why Validation Is the Key to Effective Hourly Rounds**

No doubt about it: **Hourly rounding** is hot. And no wonder. In 2006 Studer Group's Alliance for Health Care Research initiated a call light study—whose findings were published in the *American Journal of Nursing*—which proves how well it works.

In addition, during the Institute for Healthcare Improvement's December 2007 Annual Forum, hourly rounding was described as one of the most powerful ways to redesign patient care, in addition to helping "restore sanity and joy to our workforce."

Since then, the tactic has been implemented in hundreds of organizations across the country. So it's no surprise that at conferences I attend, discussion invariably turns to this subject. When leaders are asked whether they are doing hourly rounds, many of them will reply that, yes, they are. And when you ask staff if they are doing hourly rounds, they will also tell you, "We're doing it."

So why don't all organizations experience fantastic results from hourly rounding? First of all, some organizations have been known to deviate from the original formula we set forth. It is critical to follow the **eight behaviors of hourly rounding**, which you will find explained in detail in the Hourly Rounding DVD and implementation guide available on the Studer Group website at [www.studergroup.com](http://www.studergroup.com).

The eight behaviors of hourly rounding are:

1. Use opening Key Words.
2. Accomplish scheduled tasks.
3. Address the "Three Ps"—pain, potty, position.
4. Address additional comfort needs.
5. Conduct environmental assessment.
6. Ask, "Is there anything else I can do for you? I have time."
7. Tell each patient when you will be back.
8. Document the round.

In our experience, the main difference between those that are successful and those that are struggling to achieve results is validation—or, said another way, lack of validation. If you want to drive the results described above, you have to *Validate, Validate, Validate*.

The most often heard excuse from staff regarding hourly rounds is, "We are already in the room that much anyway," or "I am already doing those things." Certainly this is the perception that many staff have; however, it is often not the reality. If it were, we would not hear so many patient complaints like, "I don't see my nurse enough," or "The staff seems so busy."

Done right and properly validated, hourly rounding *will* improve your patient care and satisfaction. Here are just a few principles to keep in mind:

**Face time is not enough.** Staff must understand that hourly rounding is not about getting in the room every hour. It is about doing the eight behaviors every hour—which just happen to require us to be in the room to do them.

**Nurse leaders, it's your job to validate.** It's the nurse leader's task to validate that the eight behaviors of hourly rounding are being implemented with enough consistency to achieve results. The key? Rounding logs. I have yet to see an organization be successful in getting the level of results we mentioned above without using them. I also advocate for the use of an annual competency that will add credibility to this skill and make it as important as all the other skills we validate annually. But even annual validation is not enough in the early phases of implementation, which can last six months or more. Nurse leaders need to continue frequent validation long enough to

ensure that the staff's initials on the log truly represents that all eight behaviors were accomplished.

**Yes, validation takes time—but it's worth it.** If the validation is so critical—why do we have such a hard time doing it? The most obvious answer is *time*. Validating skills directly by observation is certainly an investment in time, but those organizations that bite the bullet and get it done will tell you the results they get far outweigh the time spent.

**Trust, but verify.** Many nurse leaders will tell me, "When I verify rounding, the staff feels like I don't trust them. They think I am checking up on them." Well...that's because you are—but it's the right thing to do. At Studer Group we call it ***trust but verify***. After all, we trust that a physician will do a history and physical on every patient, but we still verify that he has done it. And we trust that a pilot will do his pre-flight checklist, but, again, we verify. As a leader on your unit, you have the ultimate responsibility for the competency of your staff. For critical skills a "trust but verify" approach is necessary—and hourly rounding does qualify.

**"Soft" validation doesn't work.** I sometimes see nurse leaders invest the time in doing the validation but use too soft of an approach to get the real value. For instance: "Sara, I appreciate being able to shadow you and validate your hourly rounding skills. I think you did a great job. The only thing I didn't hear was you using the closing key words. I'll go ahead and check you off but please be sure to do them next time." In this case, we have left open the door for Sara to continue to forget to use one of the eight behaviors of hourly rounds—*Use closing key words*.

**Take the ACLS approach.** I recommend you use an approach most clinicians are very accustomed to if they have ever tested for ACLS or similar certifications. That is, you need to be 100 percent correct to pass certification. You would *never* be ACLS certified and have them say, "You were pretty close on that dose of medication; just be sure to check closer next time." If you are validating skills, take an ACLS approach and give specific and immediate feedback on each of the eight behaviors. This way the staff will know what they are doing well and what they need to do differently.

With diligence in validating skills, a tighter discipline to get all eight behaviors done well, and verification that they are actually occurring with every patient...the results will come. For more information on how to effectively implement hourly rounding in your organization please contact George Scarborough by email at [george.scarborough@studergroup.com](mailto:george.scarborough@studergroup.com).

Yours in service,

Lyn Ketelsen, RN, MBA  
Studer Group Coach Leader  
[lketelsen@studergroup.mmsend.com](mailto:lketelsen@studergroup.mmsend.com)



## **10-State Project to Study Methods to Reduce Central Line-Associated Bloodstream Infections in Hospital ICUs**

As part of an AHRQ-funded project, hospital associations in 10 states have been selected to participate in a program to test methods of reducing central-line associated blood stream infections in hospital intensive care units (ICUs). The states are California, Colorado, Florida, Massachusetts, **Nebraska**, North Carolina, Ohio, Pennsylvania, Texas, and Washington. In addition, the California Hospital Patient Safety Organization, the North Carolina Center for Hospital Quality and Patient Safety, and the Ohio Patient Safety Institute will participate in the project. The hospital associations and patient safety groups were chosen to participate based on their capability and infrastructure to implement the safety protocols being tested in the project. In addition, they provide a broad geographic representation. Last October, AHRQ awarded a 3-year, \$3 million contract to the Health Research & Educational Trust, an affiliate of the American Hospital Association, to coordinate the project. The project will continue the work that originated at the Johns Hopkins University School of Medicine in Baltimore and was later implemented statewide in Michigan by the Johns Hopkins Quality and Safety Research Group and the Michigan Health & Hospital Association. The project will implement a comprehensive unit-based patient safety program across the 10 states to help prevent infections related to the use of central line catheters. Select to read our [press release](#) announcing participating States and our earlier [press release](#) on the award of the contract.

## **Educating Patients Before They Leave the Hospital Reduces Readmissions, Emergency Department Visits and Saves Money**

Patients who have a clear understanding of their after-hospital care instructions, including how to take their medicines and when to make follow-up appointments, are 30 percent less likely to be readmitted or visit the emergency department than patients who lack this information. Fewer hospital readmissions and emergency department visits also translate to lower total costs. The AHRQ-funded study found that total costs (a combination of actual hospitalization costs and estimated outpatient costs) were an average of \$412 lower for the patients who received complete information than for patients who did not. The study, "A Reengineered Hospital Discharge Program to Decrease Rehospitalization: A Randomized Trial," is published in the February 3 issue of the *Annals of Internal Medicine*. Select to read our [press release](#) and select to access the abstract.

*Editor's note: emphasis in the article is mine.*



To view the **SONAR** website, Calendar of Events, Member Hospitals, & Resource Links visit:  
<http://www.chmccook.org/sonar.htm>

**SONAR Mission Statement: To assist health care facilities in education, networking, and resources to meet regulatory compliance.**

**SONAR** is a group of healthcare professionals (Safety Officers, Risk Managers, Infection Control, Environmental Service, and Maintenance Directors, Quality Improvement, etc.) started in 1998 in southwest Nebraska. Members represent large and small licensed facilities, sharing a common goal, *Safety*. Membership is as far west as Chadron and has been as far east as Columbus.

**SONAR** meets bi-monthly, typically the last Friday of the month, with meetings held in North Platte. (If a holiday falls on the last Friday we will schedule another meeting date).

Annual membership fees are \$100.00 per facility. Members are encouraged to bring others from their facility to the meetings when the subject matter pertains to their area of interest.

## **Safety Healthcare Conference**

This conference is held annually in North Platte. Every hospital, a large number of medical clinics and nursing homes in the state is invited to attend. We cover topics that our attendees have identified and bring in a variety of vendors for attendees to visit with, see new products, and discuss need to know issues.

## **Resources**

We have received assistance from many organizations and businesses.

A few of those include, but are not limited to:

**Central Community College**

**Nebraska Safety Council**

**Nebraska Environmental Training Center**

**Nebraska Department of Environmental Quality**

**Center for Biopreparedness**

**Nebraska Workforce Development**

**State Fire Marshall**

With the assistance of the resources listed and others, we strive to meet the regulations set by OSHA, EPA, and Joint Commission, federal, state and local regulations.

If you are interested in learning more about this or in networking, sharing ideas, policies and procedures, checklists, and brainstorming with other healthcare professionals; contact us today. We truly believe that Working Together Just Makes Sense!

If you would like to join **SONAR** or have additional questions or comments please contact:

Dari Olson, **SONAR** Chairman

Safety Director, McCook Community Hospital

Phone 308-344-8362

Email: [dolson@chmccook.org](mailto:dolson@chmccook.org)

## **TeamSTEPPS™ Featured in Pentagon Web Radio Podcast**

A recent Pentagon podcast features Army Col. Peter Napolitano, a physician champion for patient safety at Madigan Army Medical Center in Tacoma, WA, describing the importance of the "huddle," a TeamSTEPPS™ strategy to improve patient care, to medical corps personnel who were preparing to deploy last month.

**Col. Napolitano's 30-minute podcast is part of a series that follows military doctors from training to deployment. Select to access the [podcast](#). Look for Episode #35: MHS Patient Safety Program TeamSTEPPS™.**

## **Job Postings**

### **Looking for a Director of Quality**

I'm on a search for a Quality Director for a position in Arizona. The hospital is close to the Colorado River, lots of water sports and the retirees come in the winter for the weather.

This position has responsibilities for all regulatory body survey, i.e., JCAHO, State Licensing Review, CMS validation surveys.

This position is responsible for planning and implementing the performance programs.

Coordinates risk programs with all hospital departments, and administration. The Director has a staff of 2 and reports to the CNO.

### **Job Description**

- At least 3 years leadership experience in a hospital setting (QRM)
- They strongly prefer this RN to have a bachelor degree

The hospital helps with relocation and pays my fee.

This hospital is also looking for a Director of Risk Management; someone who knows TMC and State and Federal Standards.

All inquiries are confidential; please send your resume/CV or call:

**Lita Emch, Executive Recruiter**

**1-800-867-0232 or 805-644-5475**

**E-mail, [tmbrlake@pacbell.net](mailto:tmbrlake@pacbell.net)**

# Next Meeting April 3, 2009 Bergan Mercy Medical Center, Omaha

## Bergan Mercy Medical Center

7500 Mercy Road  
Omaha, NE 68114

Website: <http://www.alegent.com/body.cfm?id=51>

Click on the link  
below to bring  
up web map:

[http://maps.google.com/maps?hl=en&q=7500+mercy+road+omaha+ne&um=1&ie=UTF-8&split=0&gl=us&ei=kiaxSfjNAY3WMluk9PME&sa=X&oi=geocode\\_result&resnum=1&ct=i](http://maps.google.com/maps?hl=en&q=7500+mercy+road+omaha+ne&um=1&ie=UTF-8&split=0&gl=us&ei=kiaxSfjNAY3WMluk9PME&sa=X&oi=geocode_result&resnum=1&ct=i)  
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## Future NAHQRS Meetings

**June 5, 2009 Kearney August 7, 2009 North Platte**  
**October TBD, 2009 Lincoln December 6, 2009 York**  
**February 5, 2010 TBD**

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**Next publish date is May 5, 2009**

Comments on this newsletter, or future articles for submission or information, or other tidbits for publication can be sent to Bill Redinger at: [wredinger@sfmtc-gi.org](mailto:wredinger@sfmtc-gi.org)

### Future Newsletter publish dates:

- July 7, 2009
- September 2, 2009
- November 6, 2009
- January 5, 2010