

From the Editors

Steven J. Wassner, MD
 For the Penn State Children's Hospital Quality
 and Safety Team

Welcome to the second issue of our Children's Hospital Town Hall Newsletter. We are trying to circulate this newsletter widely throughout the Children's Hospital so that even if you can't make the actual Town Hall meeting, here's another chance to keep up to date with our projects, our plans, our successes, and even those areas where we find we have fallen short of our goals and need to do better. We hope you like what you see and are energized and encouraged enough to become a part of the team. There are lots of ways to help. We can all become more quality-conscious with actions as straightforward as remembering to wash or sanitize our hands before and after patient contacts; performing pre-procedure "time-outs" and maintaining appropriate chart documentation. Next, move one step up past personal performance and help us improve the organization. Occurrence reporting is a wonderful tool for bringing attention to both real and potential problems. Don't wait for an accident to happen before submitting a report. An occurrence report about a "near miss" can alert us to a potential system problem and allow us to correct it before anyone is actually harmed. Still anxious to do more, there are ongoing projects and numerous quality improvement committees that can always use another willing mind and helping hand. We welcome new members to our committee with the promise that the time you spend working on quality improvements will fit in well with the very reason you work here, to provide the best possible care for the children and families that we serve.

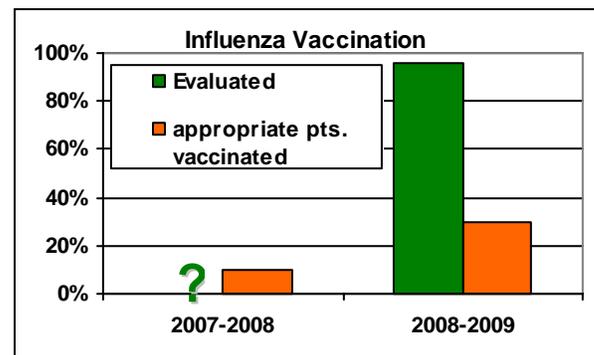
Influenza Vaccine Update

Dr. Gavin Graff
 Chief, Division of Pediatric Pulmonology

This serves as an update on the Penn State children's hospital influenza program. Evaluation of our results during the 2007-2008 influenza season demonstrated that only 5/61 patients who should have received the flu vaccine were actually vaccinated during their hospitalization. As part of an institution-wide effort to immunize against the influenza virus, our goal is to ensure that all pediatric admissions are evaluated on admission and that all appropriate patients are immunized during their hospitalization.

The program is a nursing-driven protocol developed by the influenza team with input from a variety of sources. We monitor our results in every inpatient admission ages 6m-18

years. This year's program went live on October 1 and this is an interim review of our results to date.



First the good news, with the exception of the Same-Day unit, over 95% of children admitted have been assessed for vaccine administration. Of those assessed, 36 (64%) should not have received the vaccine. Some of the reasons not to give the vaccine included previous vaccination this season (21%), active fever or immunosuppression (20%), lack of parental consent (6%). However, of the 20 children who were determined to be appropriate vaccine candidates, only 6/20 (30%) received the vaccine prior to discharge. The goal of the nationwide influenza program is to immunize all appropriate children. Using that standard, only about 30% of the children we see are still not immunized. This year, Pediatrics at Cherry Drive alone has immunized approximately 3,000 individuals. While our success at immunizing hospitalized children is significantly higher than last year's immunization rate, it is clear that we still have room for improvement.

Where can we improve? The committee is in the process of identifying all of the barriers which are preventing eligible patients from receiving an ordered vaccine. Multiple areas have been identified so far and we are far from done. Some of the problems identified include; 1) the influenza admission PowerChart form not being filled out correctly; 2) physicians have occasionally asked parents not to consent to vaccination; 3) when the immunization is rescheduled it falls off the record so that the vaccine order does not fire; 4) lack of vaccine availability.

All told, about half the patients who have an order generated for the influenza vaccine never actually get vaccinated. All told, about 15 patients per week who should be getting vaccinated leave our hospital unprotected. The committee will continue working on this population to try to improve the overall results. The committee thanks everybody for engaging in this program and is hopeful that our influenza vaccination results will improve over the final months of the flu season.

Your ideas and thoughts on identifying any other barriers you have encountered are most welcome!

The Pediatric Rapid Response Team (PRRT)

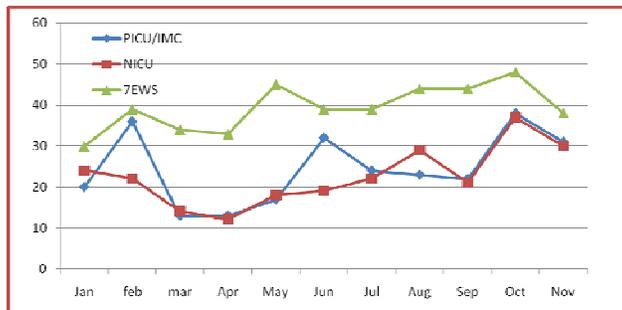
Dr. Tracy Prematta
Chief Resident, Department of Pediatrics

The pediatric rapid response team (PRRT) will respond to any deterioration in the condition of pediatric patients throughout the Children’s Hospital. The goal of this program is to improve patient care by preventing in-hospital adverse events and unexpected cardiopulmonary arrests. The PRRT is an added layer of patient protection and is not meant to take of the place of timely and appropriate management by the primary service. The PRRT will consist of a senior pediatric resident, the PICU charge nurse, a respiratory therapist, and the patient’s nurse. It can be triggered by any hospital employee who feels a change in patient status warrants an evaluation by the team, and is done by dialing ext 8888. The operator will then activate the appropriate pagers and the team will respond within 15minutes. At the same time, the attending of the primary service will be notified that a PRR has been called, and they or an appropriate team member will also come to the bedside. Events leading up to and including the PRR will be documented in PowerChart by the patient’s nurse, the primary service, and the team leader. An integral part of this process is the anticipated review of each PRRT event. Highly successful organizations utilize information to improve their processes. We hope to learn from each event and, over time, decrease number of PRRT calls. Education regarding the PRRT will take place throughout the Children’s Hospital with a goal start date of Dec 22nd. This program continues to evolve and we anticipate continued program modifications over time. We appreciate everyone’s cooperation and look forward to your feedback.

Occurrence reporting

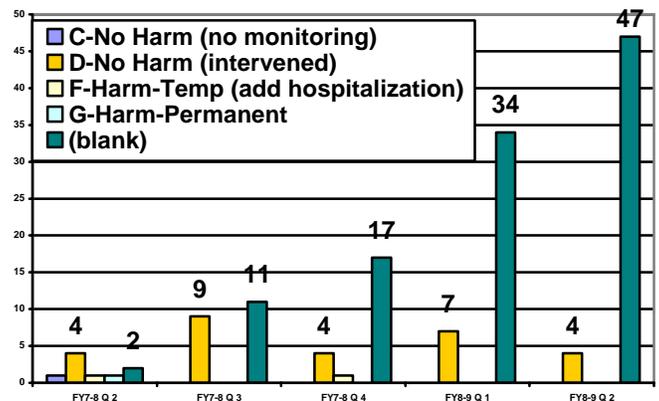
Gloria Gingrich, RN
Pediatric Clinical Performance Specialist

In the first issue of our Town Hall Newsletter we spoke about the importance of occurrence reporting and noted that since the start of computerized occurrence reporting there has been a steady increase in the number of occurrence reported with each month.



In the past, there was no way to collate the large number of hand-written occurrence reports received each month. With computerized occurrence reporting we can track the various types of occurrences and use that information to improve care. Each occurrence report receives a severity score. Occurrences with high severity scores are investigated immediately. Those with lower scores are grouped so that we can examine the processes involved. Some types of errors are best dealt with through staff education, others by changing equipment or processes to eliminate the possibility of error. Recent examples include the use of standardized “time-outs” before surgery or the changing the weighing scales in pediatrics to ensure that they read out only kilograms and not pounds.

One area of interest is IV infiltration. While this is a problem throughout the hospital, for obvious reasons, IV infiltration is particularly dangerous within our younger and smaller pediatric patients. Last April we began a major project to decrease the incidence and severity of IV infiltrations throughout pediatrics. Our work has led to a full-scale reevaluation of our policies regarding peripheral IV infusions. Not surprisingly, the project turned out to be more complex and involve more aspects than we thought. We hope to roll out the new program early in the New Year. Below is a graph of the IV infiltrates reported through Cerner over the past 5 quarters. Please remember that Cerner occurrence reporting began at the beginning of the third quarter, of last year.



As you can see, the graphs are only as good as the data entered. It appears that we have had a decrease in the number of serious incidents. Unfortunately, over the past several quarters, the most common harm entry has been “Blank”. A golden rule for occurrence reporting is “when in doubt, fill it out”, and remember if you want change “just do-it!”

If you have any suggestions about projects or areas that we should be examining, just drop me a line via email at ggingrich@hmc.psu.edu. Remember, the more people involved in quality improvement, the better it gets.