PENNSTATE HERSHEY Children's Hospital

PENNSTATE HERSHEY Milton S. Hershey Medical Center

Quality and Safety Committee

Volume 2 Number 1

From the Editors:

Kelly Kreider Parent Representative

Hello. My name is Kelly Kreider. I am the parent of a child who has used the services of the Children's Hospital many times over a 13 year period. Because of our time spent here and our experiences I was asked to sit on the Hospital's Quality and Safety Committee. They wanted a parent/patient's perspective on what we would see as quality and safety issues. They knew that they don't always "see" everything a parent might observe while spending time in the hospital or clinic with their child.

It has been a great experience to spend time on the committee. It makes me feel like I can give something back and help provide and even safer environment to those children and their families who will pass through these doors in the future. I am impressed with the depth and scope that the Q and S committee looks at issues. They work hard at processing information, facilitating new initiatives, and monitoring the progress of the practices that have been put into place.

It has been a great learning opportunity for me and I'm honored to be a parent representative on this important committee.

Congratulations

The Safety and Quality team would like to congratulate the following individuals on their swift and appropriate action to prevent or limit harm

Amanda Ebbert, RN	Patricia Engasser, RN
Heather Lazusky, MD	Gretchen McCullough, RN
Stacey Miller, LPN	Janelle Porath, CNP
Saba Sheikh, MD	Barbara Smith, RN

Annual Influenza Update

In an average year, somewhere between 5-20% of the population gets influenza and more than 20,000 people are hospitalized due to influenza-related problems. In the USA, the same number of people die from influenza as motor vehicle fatalities (about 36,000/yr) and influenza deaths are disproportionately higher in children. While current recommendations are for influenza immunization for all infants and children older than 6 month of age, a significant percentage of our population is still unimmunized.

Two years ago we began a program to immunized all appropriate patients hospitalized during the influenza season. At that time the percentage of children immunized was quite low (approximately 10%). Last year the pediatric influenza committee worked with physicians, nursing and our information technology group to improve our immunization rate and we improved our success rate to about 60%. Over the past several months the committee has continued meeting and working to improve our processes still further. Among the committees current recommendations/initiatives are the following: 1) for those children who are scheduled as elective admission, we will be recommending to the parents that their child be immunized before admission, this will make it less likely that they will have to cancel the admission due to illness or that they will develop or pass on influenza while a patient in our hospital. 2) We have simplified the evaluation process to allow us to evaluate admission and where appropriate, administer the vaccination within hours of admission. 3) Daily updates as to immunization status of all of our unit patients.

Finally, it's important to deal with these 3 common vaccine myths.

1) Everyone gets fever from vaccine
   Last year, only 1/50 last children receiving the vaccine at the PSCH developed a fever
2) I will develop influenza from the flu vaccine!
   The injectable vaccine we administer is made of "killed" virus and can't cause influenza in anyone
3) The vaccine is not effective
   Studies have shown that the vaccine is about 80% effective in preventing influenza infection.

Pain Minimization

Robert Tamburro, MD

The Children's Hospital Pain Initiative is involved in three projects. First, the group is about to begin distribution of the Pediatric Patient Pain Bill of Rights. While we realize that we cannot promise a pain-free experience, we recognize our responsibility to listen to and work with, patients and families to limit any and all painful experiences and procedures. This document has been reviewed, modified and approved by multiple groups throughout the Children's Hospital and will be prominently displayed throughout the Children's Hospital and on individual placards in each patient room. The tentative plan is for the document to be publicly distributed later this fall. The initiative wishes to thank all those individuals who have provided input into the project.

Some of the most common painful procedures involve needle sticks either for blood draws/IV starts or lumbar puncture. We

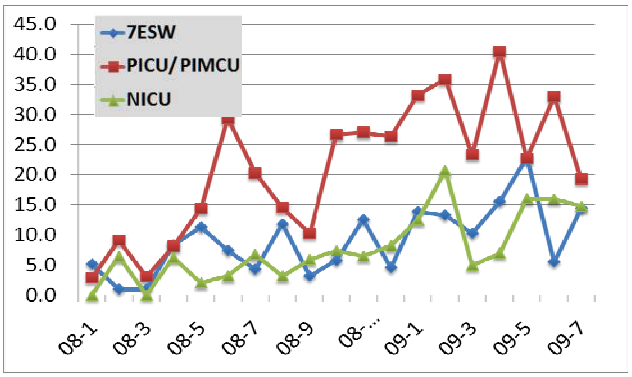
are working to increase the use of the topical anesthesia for these events. Currently, two topical anesthetic creams, LMX and EMLA cream are available in our formulary. As of January 2009, orders for LMX or EMLA were associated with 17% of all peripheral IV starts and lumbar punctures in non-surgical pediatric patients. After an educational intervention, that number increased to 38% in July 2009. Although the improvement was marked, there remains much room for improvement. To improve our utilization, we are now moving to change the appropriate Cerner order sets to include, LMX or EMLA as the standard.

Finally, the Children's Hospital Pain Initiative has created a survey for patients and their caregivers assessing their pain and its treatment during their admission. We will begin distribution of this survey in the ensuing few weeks. We hope that this survey will provide a better understanding of how we are perceived by the families we serve and where we can next work to improve our efforts.

Laboratory Errors

Steven Wassner, MD

The use of occurrence reporting has allowed us to "drill down" on specific areas and get a better understanding of occurrences within the Children's Hospital. One area of particular concern to the Quality and Safety Committee is the laboratory errors. Laboratory errors account for a significant percentage of the total occurrence reports generated throughout the Children's Hospital and for the most part, correction of these errors is within our reach. Since we moved to the computerized recording of occurrences about 1 ½ years ago it has become possible to track these errors over time.



Total laboratory errors /1000 patient days

Even more informative is the breakdown of these errors by unit and by error type.

Unit	*Label* /100PD - (%)	*Quality* /100PD - (%)
NICU	1.8 - (44%)	2.7 – (28%)
PICU/PIMCU	6.9 - (43%0	5.5 – (35%)
7 ESW	2.4 - (38%)	2.7 – (39%)

Occurrence Rates/1000 Patient Days and % of that Unit's Total Laboratory Occurrences

It appears that for all units, the majority of occurrences are in just two categories, specimen labeling and quality. We can improve specimen quality in two simple ways; first, be sure to clear the line before drawing specimens, and second, adhere to the correct order in which the tubes must be drawn. If the order is incorrect, it is possible that the remaining specimens will be contaminated. We have provided posters listing the proper order to each of the wards.

Prevention of labeling errors is more complex. At the Town Hall Meeting we heard a variety of comments regarding ways to improve this process. We will continue to assist the Unit Nurse Managers as we work to further decrease these error rates.

This is only one example of the power of the computerized occurrence report system to help us collate information from a variety of sources. The first, and most important aspect of this process is the identification of occurrences, even those that do not reach the patient (near misses, close saves). These provide an early alert which allows us to improve our processes and prevent further serious problems.

Occurrence Reporting

Steven Wassner, MD

One of our most powerful tools to improve safety is our computerized occurrence reporting process. It's clear that we can't fix what we don't know about and we rely on the self-reporting of our Children's Hospital community to identify both actual and potential problems. As you can see in the Congratulations section above, we are proud to commend our co-workers on their recognition and prompt action and willingness to submit occurrence reports.

As we have become more familiar with the occurrence report system it is clear that we are receiving more reports of "Unsafe Conditions' and "Near Misses." Reporting these categories of error and identifying these <u>potential</u> problems allows us to re-examine our processes and procedures to prevent these problems in the future. That adds a very strong tool to our arsenal. Please keep up the good work and keep logging occurrences both for the events themselves and for the near misses that you find that prevent actual errors from occurring.

Percent Change in Rate of Occurrence Reports by Fiscal Quarter (/1000 patient days)