#14

THE CHILDREN'S
HOSPITAL OF BUFFALO

Pediatric Otolaryngology

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KALEIDA
HEALTH

An affiliated teaching hospital of the School of Medicine and Biomedical Sciences State University of New York at Buffalo

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December 3, 2002

Ms. Cathy Blake
Director of Quality Initiatives
Office of Health Systems Management
State of New York
Department of Health
Room 401
5 Penn Plaza
New York, NY 10001

Dear Ms. Blake:

Enclosed are four copies of the New York Safety Award submitted by Children's Hospital of Buffalo, Kaleida Health.

If you have any questions please feel free to contact me at 716-878-7643.

Thank you for your consideration.

Sincerely,

Linda Brodsky/ma

Linda Brodsky, M.D.
Professor, of Otolaryngology & Pediatrics
Director, Center of Pediatric Quality
State University of New York at Buffalo
School of Medicine & Biomedical Science
Director, Pediatric Otolaryngology
Children's Hospital of Buffalo

NYS DOH Award for Quality Improvement
December 2002

Application from: Children's Hospital of Buffalo
Center for Pediatric Quality
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716.878.7570 (Rachel Anderson, contact person)
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Demographics:
Children's Hospital of Buffalo (CHOB) has 313 certified beds. The pediatric beds include 107 general pediatrics, 54 neonatal ICU, 18 pediatric ICU, 67 newborn; 67 beds are designated for women's services. CHOB is one of five hospitals in the Kaleida Health system, the single largest healthcare system in Western New York.

Linda Brodsky, MD FAAP FACS
Director, Center for Pediatric Quality
Professor of Otolaryngology and Pediatrics
Chief, Pediatric Otolaryngology
Co-Primary Investigator

Michael Leonard, MD FAAP
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Assistant Professor of Pediatrics
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Co-Primary Investigator

Background and Introduction:
Since 1996, CHOB has had a Center for Pediatric Quality (hereafter the CPQ, formerly the Resource Utilization Committee and the Center for Improved Outcomes in Children's Healthcare). The CPQ has subsumed all of the quality assurance and improvement processes under a single, physician-led umbrella. The CPQ focuses on achieving high impact, rapid cycle improvement with broad implementation success and high personal ownership through low cost strategies and technology that is within reach. Success is measured at project initiation and thereafter as clinical, financial and satisfaction outcomes. The CPQ has thus adopted a balanced metrics approach to the continuous improvement of critical outcomes, labeled "integrated outcomes". (For a complete listing of the project teams, progress and impact, see Attachment 1).

The CPQ is supported by an organizational structure that is fluid, and includes other health care providers, administrators, technical support (e.g., medical records, financial analysts, risk management, and process improvement), and support staff (e.g., statistical analyst, data entry person, and secretarial). CPQ reports to the Chief Operating Officer of CHOB, the Medical Executive Committee of Kaleida Health, and the KHQIPSC (Kaleida Health Quality Improvement and Patient Safety Council). This integration into a large, culturally diverse, multi-hospital system gives us the ability to trial our work in adult settings that range from community based hospitals to tertiary care academic institutions. The Chief Medical Officer, who oversees quality for CHOB, and the

Medical Safety Officer both sit on the executive committee of CPQ which meets monthly to review the progress of the project teams that are currently active.

The CPQ and Safety

Early in its history, and long before the well-known Institute of Medicine Report on medical errors, the CPQ recognized that errors are a leading cause of morbidity and mortality (National Quality Forum, consensus report 2002, Institute of Medicine Report). To address this large-scale concern, the CPQ launched many projects and initiatives focused on identifying and rooting out error in our health care system. The CPQ has a proven history of success in:

- Initiating projects and achieving fundamental changes that have significantly improved patient and healthcare worker safety, and
- Implementing a substantive cultural change within the facility: A culture of safety and quality.

The CPQ is a charter member of the 18-organization national children's hospitals collaborative, the Child Health Accountability Initiative (CHAI), a part of the Child Health Corporation of America (CHCA). This membership has allowed the CPQ to fill a leading role in medication safety projects since the CHAI's inception in 1998. In recognition for the CPQ's proven history in related projects, the CPQ was selected to be the organizing team for the CHAI for their first multi-organization initiative, which was focused on medication errors[1]. Our continued participation allows us to trial improvement strategies throughout the collaborative and to benchmark our progress against similar institutions. The ability to compare adoption of improvement strategies in more than one institution has allowed us to overcome the barriers to and develop the solutions for implementation to other sites within our health system. This unique experience would be useful to the NYS DOH's goal of adapting successful practices to other institutions within the state.

Specific current examples include two project teams that are now standing teams. One is the QA Data Surveillance Team, which monitors the oversight agencies' requirements of such activities such as monthly reporting of departmental activities. The other is the **CHECKS** (Children's Hospital Ensuring Comfort and Kids Safety) Team, which concentrates on the CHOB's patient safety and pain management programs. Patient safety and pain management have been melded into one initiative because of the many safety issues surrounding proper pain control. In addition, many of the same clinical champions are involved in both projects.

The CPQ has also developed a model to spread solutions and strategies throughout CHOB in order to maximize outcomes-related results and breadth of implementation. The model is complementary to PDSA-like models and is focused on cultural change.

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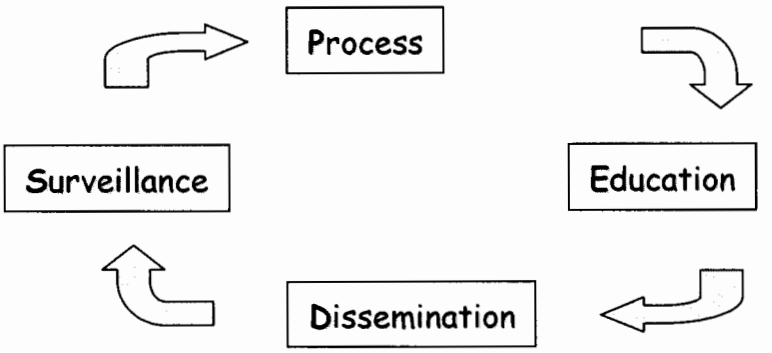
[1] Cimino MA, Kirschbaum MS, Brodsky L, Shaha S for the Child Health Accountability Initiative. *Assessing Medication Prescribing Errors in Pediatric Intensive Care Units*. Accepted with Revisions to Critical Care Medicine, August 2002.

The model has four elements: process (P), education (E), dissemination (D), and surveillance (S): **PEDS** (see Figure 1):

- Process: Identifying, designing and implementing strategies to improve care.
- Education: Arming crucial personnel with needed knowledge, skills and tools.
- Dissemination: Sharing and integrating information with all participants within the "culture of safety" to achieve collective success.
- Surveillance: Post-implementation vigilance to ensure continued improvement.

Figure 1.

PEDS Cycle of Patient Safety Improvement



Future Goals:
This award will enable the CPQ to continue to use an integrated outcomes approach, which includes assessment of clinical improvement, financial impacts and customer satisfaction, to expand the PEDS model with specific attention to the education and surveillance aspects of medication safety. The CPQ is focused on making substantive and tangible improvements in patient safety. We strive to ensure not only the best use of medications but also an environment that is free of errors and preventable adverse events.

SAFETY INITIATIVES

Prescribing Errors

In 1998, the CPQ determined to focus on identifying and reducing medication-related errors. We detailed the process of inpatient medication prescribing, and outline this complex process involving multiple steps and numerous healthcare professionals. We then conducted detailed studies of medication errors through an exhaustive chart review of over 21,000 medication orders. This data led to the identification of specific areas of improvement for which strategies were developed and implemented, with significant results achieved. The first step in the medication prescribing process served as the initial choice for study and change. The rationale for this decision is fundamental. If the order

is not written properly, attempts to intercept errors downstream become increasingly difficult.

Health care providers receive new information at a rate that exceeds anyone's ability to process and retain. With that in mind, the ability to enhance information access is critical to correct use of that information. Although computer order entry has many anticipated benefits, it has significant barriers to successful use and implementation. Cost and point of care accessibility are just two of the many reasons hospital systems have been unable to merge technology with practice. This section, using the PEDS model, describes our successful quality improvement projects, which have been and are being implemented in our facility.

P--PROCESS

Process change resulted after the identification of the many occurrences of incomplete (100%) and incorrect (0.4%) orders. Errors, adverse events, and significant inefficiencies for the nurses and pharmacists prompted these process changes.

Two separate initiatives were undertaken to reduce errors in medication orders:

- **Improving Order Completeness:** Improved order forms for better completeness and accuracy.
- **Improving Order Information:** Improved access to information for best order content.

Improving Order Completeness

The initiative for improving order completeness was elegant in its simplicity, and included two "innovations". First, the CPQ created a **Forced Function Format** medication order form (Attachment 4). The form requires the physician to fill in each appropriate field corresponding to a necessary component of a proper medication order. Two new fields were incorporated into the traditional order. The first, specific to the needs of weight variation in children, was the requirement for **Dose per kilogram (Dose/kg)**. Nurses and pharmacists can now double-check weight-based calculations and report any discrepancies immediately to the prescribing physician for correction or clarification.

The second innovation, applicable to *all* patients, is an **Indication** field. The physician must write the indication, or reason, the medication is being ordered. This not only reinforces the cognitive aspect of medication prescription, which is especially important in a teaching facility such as ours, but also gives the nursing and pharmacy staffs insight into the physician's thought process. If the medication order does not correlate with the indication cited, communication is fostered among the members of the healthcare team. This has become increasingly important as more and more medication names sound and look similar, and can easily be mistaken for one another (e.g. Celebrex, Celexa, Cerebyx). The **Indication** field has also become invaluable to our medication error surveillance process, as discussed below (See *Surveillance*).

Improved Order Information
Simultaneous with the implementation of improved order forms, the CPQ provided PDAs (personal digital assistants, e.g., Palm Pilot ™) to house staff. The use of PDAs not only gives the ability to disseminate information at the point of use, but also preserves the educational aspect of medical treatment. PDA use is common and increasingly applied. Low cost, immediate access and ability to carry large data sets makes it a very useful tool. We are in the second year of house staff use of PDA's which have software that include a Epocrites for medication and dosing references, and the Harriet Lane Red book for reference to common conditions and their recommended treatments. On most nursing units assessed a 48% reduction overall was realized for incorrect drug selection, dose and frequency during a one year observation period attributable to the use of PDAs.

Barriers and their Solutions: Although younger physicians are likely to use PDAs, older ones are unlikely to be early adopters. We would overcome this resistance to change with the following strategies:

First quarter:
- Survey all medical and house staff for their use/attitudes towards PDAs—identify early adopters.
- Offer teaching seminars, one-on-one
- Introduce a stepwise adoption schedule with target date for full implementation

Second quarter:
- Load up early adopters with PDAs and software and follow medication errors and ADEs compared to non-utilizers.

Third/Fourth quarters:
- Analyze the data for the two groups and devise change strategies based on the findings.

E--EDUCATION

Forms alone cannot solve the problem of medication errors; simply implementing a new form is ineffective at changing behaviors and creating a culture of patient safety. While efforts thus far have demonstrated improvement, elimination of prescribing errors and implementation of completeness of medication prescribing is far from being accomplished. To this end, we have created the **CHECKS Website (www.chob.edu\checks).**

The website has two components. The first section is a tutorial, providing the background for patient safety and reviewing the initiatives undertaken at CHOB. The second section is a competency exam. The user is provided with a brief case scenario, after which he/she is directed to "write" four medication orders, in increasing difficulty, pertaining to the scenario. If an error is made in any of the orders, the user is directed to make the appropriate correction. Once the user successfully completes the website, he/she is certified to write Pediatric medication orders at our facility, and electronic notification is sent to the Medical Safety Officer.

Barriers and their Solutions: To date more than 250 resident physicians have successfully completed the website. Our goal is to achieve 100% certification for all prescribing practitioners at CHOB, including attending physicians, resident physicians, pediatric nurse practitioners and physician assistants (about 750 total). As one might expect, this is an enormous undertaking. With the assistance of the Office of Graduate Medical Education at the State University of New York at Buffalo, the website is now a requirement of all new resident physicians during their orientation. Our challenge is to reach all of the residents within our consortium, our entire medical staff, and all other prescribing practitioners within our system.

First Quarter:

- Compile a list of all practitioners who are active at CHOB
- Create a monitoring process with the help of data base systems and medical staff office personnel

Second Quarter:

- Inform all practitioners of the new certification process, its justification, and timetable for implementation
- Establish pharmacy data base that would monitor by prescriber for accuracy and completeness of orders

Third and Fourth Quarters:

- Verify compliance with completion of website
- Begin to track and trend performance by practitioner

D—DISSEMINATION

Sharing information is a challenge given the enormous amounts of unfiltered information distributed to everyone in a health care organization on a daily basis. Having this information integrated into daily behavior is even more difficult. In order to share and integrate the information regarding medication safety, two strategies are being implemented:

- **FAX Newsletter.** The Chief Medical Officer, Dr. Craig L Anderson, has a well established weekly FAX and email one page newsletter that is sent to all medical and house staff at CHOB (see Attachment 3). It enjoys nearly 100% readership due to its predictable schedule, use of short, to the point pieces of information, including data on "how we are doing", and length (limited to one page—see enclosed). Administration dedicates one of its weekly newsletters per month to the CPQ for safety-related news. This enabled CHOB and the CPQ to inform the entire organization of strategies underway and improvements achieved, further strengthening our culture of safety.
- **CHECKS.** CHOB and the CPQ unveiled the CHECKS program in October 2000: *Children's Hospital Ensuring Comfort & Kids Safety*. During the Patient Safety Week, the child-friendly mascot, **Double Checks**, or **DC** for short, was also introduced (see Attachment 2). The

event showcased the many innovations developed and improvements achieved throughout the facility. Awareness of patient safety issues was targeted toward all staff, not only those directly involved in patient care. The week culminated in a citywide Pediatric Grand Rounds presentation given by the Medical Safety Officer. DC can now be found throughout the hospital, serving as a constant reminder to our personnel to maintain and promote patient safety.

Barriers and their Solutions: Funding for monthly FAX Newsletter requires support personnel to identify the data and graphically display the data for accessibility to busy health care providers. An eye-catching, to the point, publication will evolve with feedback over time. We estimate a .1 FTE administrative assistant will be needed and a schedule of publication will have to be incorporated into the format that now exists.

S--SURVEILLANCE

One of the largest obstacles to overcome in medication safety is the surveillance of practitioners for prescribing errors and resultant adverse events. This should lead to improvement and prevention *in real time*. Retrospective analysis of errors provides insight into behavior patters, but does not help the patient already harmed by an adverse event.

The **Indication** field of the improved medication order form serves as a major surveillance strategy. A true example illustrates the success and enormous potential of this innovation:

> In our Neonatal Intensive Care Unit (NICU), a resident physician wrote a complete order for aminophylline, a drug often used in premature infants to assist their breathing. However, in the **Indication** field the resident physician wrote "sepsis". The pharmacist noted the apparent discrepancy, and called the NICU. The resident physician acknowledged the error, and immediately provided the pharmacist with the correct order for *amphotericin*, a potent antifungal agent.

If the resident physician had not completed the **Indication** field, not only would this neonatal patient have received the wrong medication, potentially resulting in respiratory distress, the systemic fungal infection would have gone untreated. In such a fragile infant, this order could have resulted in a fatal outcome.

Barriers and their Solutions: Adoption of new procedures and processes are often resisted beyond the training period for most practitioners. To overcome this, see strategies under *Education* for implementation and cultural adoption of the requirement for "Indication" to be a component of every medication prescription.

DATA

Improving and maintaining complete orders reduces the risk of error. CHOB now performs chart audits on a quarterly basis to monitor for completeness of medication orders. Figure 2 shows the percentage of complete medication orders on a Pediatric medical ward for all four quarters of 2002. Several key points should be noted. The traditional components of an order, i.e. medication name, dose, route, and frequency, began with a high percentage of completeness, but have still shown improvement. The innovative portions, **Dose/kg** and **Indication**, started with a poor compliance rate, but have shown marked improvement over time. Of particular interest is that the third quarter marks the beginning new academic year, when our new interns start their first clinical rotations. Despite their inexperience, the improvement rates continued to increase. This reflects the success of our website education. The slight decrease seen in the fourth quarter **Indication** field reflects the need to provide continuous education and feedback to our resident physicians.

Figure 2: Quarterly Percentage of Complete Orders: Medical Floor

Year 2002	Medication	Dose/kg	Dose	Route	Frequency	Indication	Complete order
1st Quarter	100%	29%	94%	97%	100%	22%	15%
2nd Quarter	100%	74%	99%	98%	100%	47%	44%
3rd Quarter	100%	84%	100%	99%	99%	70%	72%
4th Quarter	100%	90%	100%	100%	100%	61%	61%

Figure 3 shows the percentage of complete medication orders on a Pediatric surgical ward for the same four quarters. We were disappointed with the initial results, but from them an invaluable lesson was reaffirmed. The majority of the orders were written by surgical residents doing only brief rotations in Pediatrics who *had not completed the website certification*. Most were in their third year of training or above, and had therefore completed orientation prior to the website becoming a requirement. *Education must accompany any patient safety initiative.* With the assistance of our surgical nursing staff, we instituted an aggressive education process for our surgical residents, resulting in the improvement seen during the most recent quarter.

Figure 3: Quarterly Percentage of Complete Orders: Surgical Floor

Year 2002	Medication	Dose/kg	Dose	Route	Frequency	Indication	Complete order
1st Quarter	100%	20%	97%	99%	99%	25%	11%
2nd Quarter	100%	48%	99%	98%	100%	34%	28%
3rd Quarter	100%	32%	98%	99%	99%	22%	17%
4th Quarter	100%	75%	100%	100%	100%	73%	68%

EXPLANATION OF PROTOCOL DEVELOPMENT AND IMPLEMENTATION STRATEGIES:

What is the CPQ?

CPQ is a group of physicians, nurses, other healthcare workers (clinical pharmacists, respiratory therapists), support staff (Resouce Management, Information Services, Financial Services, Medical Records), administrators and researchers who are responsible for quality assurance and process improvement for Pediatrics at the Children's Hospital of Buffalo (CHOB).

How does the CPQ Function?

CPQ has a unique structure that facilitates function. Organizationally, participation is open to anyone who wants to commit to the philosophical underpinnings the Center has adopted. Functionally, it follows a prescribed methodology that requires the following elements:

- Physician driven quality initiatives
- Data driven quality initiatives
- Integrated outcomes approach to all projects—clinical, financial and customer satisfaction outcomes are all identified and analyzed
- Monthly meetings that are facilitated by a data analyst who has process improvement and organizational change skills.
- Upon project completion, a brief report is written to document outcomes and their effects (see attachment 3).

What is the administrative structure of the CPQ?

CPQ is a part of the Women and Children's Research Foundation and is also responsible to the CHOB Medical Director, Craig Anderson, MD, who also sits on the executive committee of CPQ.

CPQ has an executive committee which meets monthly to hear the progress reports of the teams. Discussion of future directions needs analysis and identification of resources for teams occurs after each team report. Executive committee meetings are open to anyone within the organization. In general, 15-20 health care professionals attend each executive committee meeting.

ATTACHMENT 1

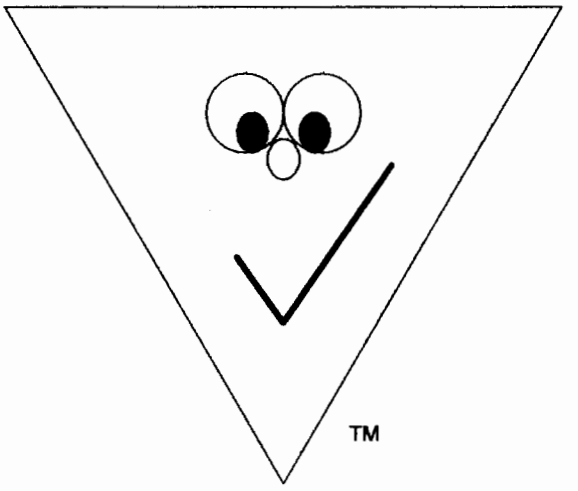
The Center for Pediatric Quality
Project Status
2002

Project	Initiator	Focus	Completion Status*	Clinical **	Financial **	Satisfaction **	avg duration (mos)
1. Sickle Cell (Pilot)	MD	clin safety; new Rx	5	2	2	0	9
2. Strabismus (Pilot)	MD	Rx vs Rx	5	1	2	2	9
3. LMA	MD	intro new Rx	5	1	2	1	6
4. Ambulatory Surgery	RN	Change oper (PI)	5	2	2	2	9
5. Pharmacy Intervention	Pharm	Change MD prescribe	5	2	2	1	6
6. Asthma in ED	MD	Rx vs Rx	5	2	0	1	18
7. Bronchiolitis	MD	CHAI care map	5	0	0	0	7
8. Head Trauma	MD	Dx change Rx	5	0	2	2	18
9. Infant Hearing Assessment	Audio	Dx vx Dx	5	2	2	2	5
10. Laser TM Fenestration	MD	new technology	5	2	2	2	12
11. Medication Errors	MD	Change MD behavior	5	2	2	0	9
12. Observation Unit	MD	Dx - Rx	5	0	0	0	6
13. Pain Management of Femur Fracture	RN	Rx change outcomes	5	NA	NA	NA	NA
14. OR PIT - Supplies	MD, RN	PI pt care	5	2	?	2	6
15. OR PIT - Staffing	MD, RN	PI pt care	5	1	?	2	6
16. OR PIT - Equipment	MD. RN	PI pt care	5	1	?	2	6
17. OR PIT - Communications	MD. RN	PI pt care	5	?	?	2	6
18. Bronchiolitis in ED	MD	CHAI	5	NA	NA	NA	NA
19. Initial Onset Diabetes	MD	Severity change RX	4	NA	NA	NA	15
20. BISONS (Nutrition)	MD, Pharm	Dx change Rx	4	NA	NA	NA	24
21. Inpatient Asthma	MD	Dx/Rx PI	3	NA	NA	NA	NA
21. Medication Administration	Pharm	PI pt care	2	NA	NA	NA	NA
23. Patient Safety-Med Errors	Pharm	PI pt care	2	NA	NA	NA	NA
24. Pain Program	MD	PI pt care	2	NA	NA	NA	NA
25. Outpatient Asthma	MD, Pharm	PI pt care	1	NA	NA	NA	NA
26. CHECKS (Safety)	MD	PI pt care	1	NA	NA	NA	NA
27. SANE	MD, RN	PI pt care	1	NA	NA	NA	NA

Project	Initiator	Focus	Completion Status*	Clinical **	Financial **	Satisfaction **	avg duration (mos)
28. Amb. Surg. - Maxiziming Pt. Satisfaction	MD	PI pt care	1	NA	NA	NA	NA
29. RADAR (Rapid Assessment of Diabetics At Risk)	MD	PI pt care	1	NA	NA	NA	NA

*Likert Scale: 1=planning stages; 2,3,4=implementation; 5=completed
**Likert Scale: -2,-1=negative impact; 0=no impact; 1,2=positive impact
NA - Not available

ATTACHMENT 2



Double CHECKS

Fax Newsletter for the Medical Staff

"Lifting Spirits, Restoring Hope, One Person at a Time"

KALEIDA HEALTH

ATTACHMENT 3

The Children's Hospital of Buffalo

Craig L. Anderson MD
Chief Medical Officer

e-mail: clanderson@kaleidahealth.org
Phone: 716-878-7928

Volume 14 Issue 3 **October 23, 2002**

Monitoring Infectious Disease

Beginning with this issue of the Fax Newsletter, Dr. Howard Faden, Co-Director of Pediatric Infectious Disease will offer his perspective on the incidence of infectious agents within our community. This will be based upon CHOB Virology/PCR Laboratory results. Dr. Faden will determine which organisms to monitor and we will use a simple method to report the weekly number of cases with an arrow indicating - ↑(increasing) →(no change) ↓(decreasing) ∅(not a factor) - comparing the incidence to previous weeks. Here is this week's data:

Adenovirus	7↑
B. Pertussis	∅↓
Enterovirus	1→
Influenza A/B	∅
Parainfluenza	1→
RSV	1↑
Rotavirus	∅

Surgeons Present Research Results

The MASC Improves Care and Decreases Cost

Drs. Colin Powers, Marc Levitt, Joselito Tantoco, Umut Sarpel, Guy Brisseau, Michael Caty, Philip Glick and Mr. Jon Rossman (Members of the Department of Surgery – CHOB) presented the results of their research on the advantages of miniature access Nissen fundoplication. The presentation was made to the Surgical Section of the AAP last week in Boston. The study involved a review of laparoscopic Nissen fundoplications over a four-year period. Comparing the standard open Nissen operation to a new miniature laparoscopic access approach demonstrated statistically significant improved rates of extubation, shorter recovery room stays, shorter duration of chest physiotherapy, fewer intensive care unit admissions, more rapid resumption of baseline feeds and overall **decreased length of stay**. Dr. Glick commented: "These differences all translated into better care for the patient and decreased cost to the hospital when compared to the previous open techniques that we were using". This work, which has been accepted for publication in the Journal of Pediatric Surgery, clearly reflects well upon the new Miniature Access Surgical Unit (MASC) at CHOB and the fine surgical team which continues to lead in the development of new surgical approaches for pediatric disease.

"*Children's Express*" to Reopen

Improved Processing in the ED

An expedited evaluation process for patients presenting to the CHOB Emergency Department (ED) and triaged "blue or green" i.e. children with fever less than 40°C, ear ache etc., will begin in early November and continue through the busy winter season. It is anticipated that this approach to patient care will reduce wait times and improve physician efficiency according to Dr. Kathy Lillis, Chief of ED.

PEDIATRIC GRAND ROUNDS
Kinch Auditorium Fridays 8:00 a.m.
November 1: *"Quality Assurance Grand Rounds: Endocrinology"*
Teresa Quattrin, M.D., Associate Professor