AHRQ Safety Program for Improving Surgical Care and Recovery (ISCR)

WHAT ISCR can do for you…

Hawaii Face to Face

September 26, 2017

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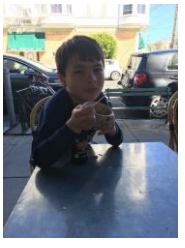
Why do we need data?

- BOTTOM LINE

If you don't measure you will never know what was done

We are all told many things every day and have the best of intentions but without meaningful performance feedback, even with the best of intentions things don't happen…..



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Why do we need data?

Just having a pathway is not enough – pathway compliance must be high to improve patient care

ERIN pilot showed that low pathway adherence increased odds of prolonged LOS 3-fold

AHRQ Safety Program for ERAS: What's Different?

Lessons Learned From ACS NSQIP ERIN Pilot

- 16 hospitals
- Colorectal Surgery

Outcome	Low Pathway Adherence	High Pathway Adherence	p-value
Length of Stay	7.79 days	4.28 days	<.001
Readmission	11.18%	8.01%	NS
Death-or-serious morbidity composite*	18.82%	8.79%	<.05

**composite measure including SSI*

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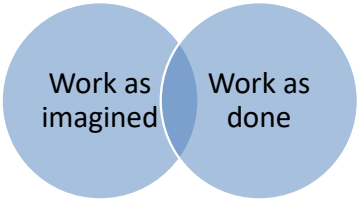
Why do we need data?

- Data collection informs the gap between "work as imagined" and "work as done"



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Why do we need data?

- Data on process measures allows you to:
  - Target education/interventions to pathway elements with low reliability
  - Demonstrate room for improvement and SUCCESS to front-line providers
- Data on outcomes allows you to:
  - Measure impact on patient care
  - Celebrate success
  - Give feedback to hospital leadership demonstrating ROI with enhanced recovery

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Process Measures

- Preadmission counseling
- Preop Mechanical Bowel Prep
- Preop Oral Antibiotics
- VTE Chemoprophylaxis
- Clear Liquids 2 hours beforeinduction
- Regional Anesthesia
- Multimodal pain management
- First Post op VTE dose (*date/time*)
- First Postop Mobilization (date/time)
- First Postop Intake Liquids (*date/time*)
- First BID Mobilization (*date/time*)
- First Postop Intake of Solids (*date/time*)
- Foley Removal (*date/time*)
- IV discontinuation (*date/time*)
- Date of Return of Bowel Function
- Date Tolerating Diet
- Date Pain Controlled with p.o. meds

ISCR Worksheet

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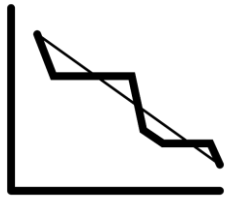
Outcome measures

- Return of bowel function (ileus)
- Surgical Site Infection (SSI: Superficial, Deep and O/S)
- Urinary tract infection (UTI)
- Venous Thromboembolic Event (VTE)
- Mortality
- Length of Stay
- Readmission



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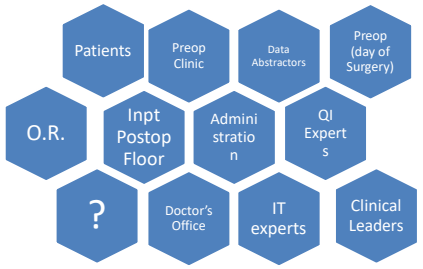
MEASURES (slide added)

OUTCOME PROCESS

Outcome Measures	Core	Optional
Date of Return of Bowel Function	Preoperative Mechanical Bowel Prep	Pre-Admission Counseling
Acute Hospital Discharge Date	Preoperative Oral Antibiotics	Preoperative VTE Chemoprophylaxis
30-Day Vein Thrombosis (DVT or PE)	Use of Regional Anesthesia	Allow Clear Liquids Up to 2 Hours Before
30-Day Urinary Tract Infection	Use of Multi-Modal Pain Management	Use of Anti-emetic Prophylaxis
30-Day Surgical Site Infection (Deep or Organ/Space)	First Postoperative VTE Chemoprophylaxis Dose	First BID Mobilization
30-Day Readmission	First Postoperative Mobilization	IV Fluid Discontinuation
30-Day Mortality	First Postoperative Intake of Liquids	Date Tolerating Diet
	First Postop Intake of Solids	Date Pain Controlled With PO Medication
	Foley Removal	
	Prolonged Foley Catheterization	

Timely Feedback of Measures

- All tied to pathway elements
- Actionable
- Improved reliability will impact outcomes



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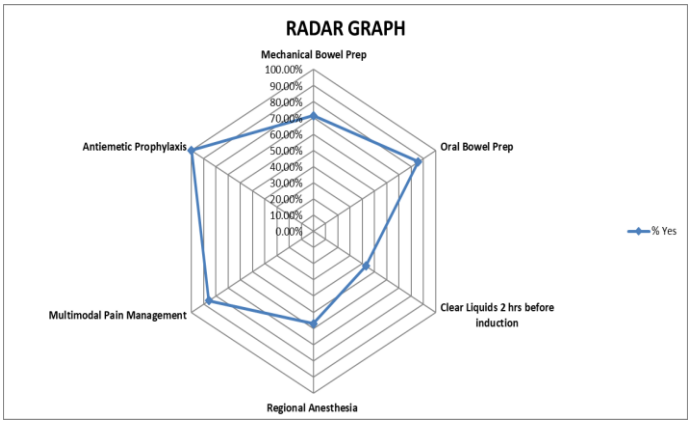
Example of Timely Feedback after 7 cases

- AND…only 1 out of the 7 patients had all 6 elements…



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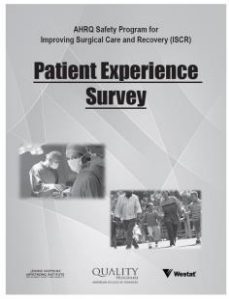
Outcome Measures: Patient Experience

- Balancing measure
- Administered by Westat: paper survey to be sent 51 days after discharge from hospital
- Hospitals with a minimum of 5 patients will receive an individualized report



What Should You Be Doing Now?

- Access Website!
- Baseline data DONE
- Goals SET
- Pathway Implementation in OCTOBER!
- Safety Survey emails to national team this week!

Access Website for support and call archives

https://qi.facs.org/iscr/login.jsp

JOHNS HOPKINS MEDICINE

AMERICAN COLLEGE OF SURGEONS
Improving Quality: Highest Standards, Better Outcomes

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Access Website for Tools

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Overview of Baseline Data

Template slide on website under

"Sample Presentation to Senior Executive"

- **Annual colorectal case volume:**
- **Length of stay (median):**
- **Readmission rate:**
- **Surgical site infection (SSI) rate:**
- **Venous thromboembolic event (VTE) rate:**
- **Urinary Tract Infection (UTI) rate:**
- **Length of stay event rate:**

*include comparison to other hospitals if available

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Top Three Goals

List your ISCR team's top 3 goals for the ISCR program at your hospital. Measurable and time defined

1. Goal 1 (e.g. reduce LOS by 20% by July 2018)
2. Goal 2 (e.g. reach 100% reliability in CHO loading by March 2018)
3. Goal 3 (….?)

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START the (updated) PATHWAY!

If you don't have an easy IT solution, consider paper to start…

Date: _____

Patient Label (or name, MRN and surgeon)

Pathway Checklist

PEROPERATIVE AREA		
Yes	No	Carbohydrate completed two hours prior to arrival to hospital.*
Yes	No	Mechanical bowel preparation completed at home
Yes	No	Oral antibiotics completed at home
Yes	No	Bathing completed at home
Yes	No	Patient education materials brought with patient to hospital
Yes	No	
Yes	No	
Yes	No	
Yes	No	
Yes	No	Forced air warming device placed on patient
Yes	No	Glucose checked and appropriate action taken
Yes	No	Regional analgesia (Epidural or TAP, completed or consented if applicable)
INTRAOPERATIVE AREA		
Yes	No	Antibiotic administered
Yes	No	Forced air warmer applied
Yes	No	Subcutaneous heparin administered**
RECOVERY ROOM		
Yes	No	If in PACU greater than two hours, is **PATIENT DRINKING?**
Yes	No	If in PACU greater than two hours, is **PATIENT UP IN THE CHAIR?**
INPATIENT UNIT		
Yes	No	Enhanced recovery order set used
COMMENTS OR ISSUES (for process improvement):		

Fill in multimodal pre-anesthesia medications in your pathway (e.g. gabapentin, Tylenol, scopolamine patch, etc.)

**Follow hospital protocol in diabetic patients*
***At some hospitals, this is administered in the preoperative area. Move this task to the appropriate section of the checklist so it reflects your hospital's workflow*

Please contact [PROJECT LEAD NAME] at [EMAIL/TELEPHONE] if you have questions about this checklist

Idea:

- **attach this checklist to the patient's paper chart**
- ask providers to note as each pathway element has been completed.
- becomes a source of **real time data collection to monitor pathway reliability**.

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Safety Survey Oct 3- 24 !

- AHRQ safety survey will provide the opportunity for specific information for *this* service line of work
- Not mandatory as we are sensitive to "over-surveying"

Patient Safety Culture Composite	Definition: *The extent to which…*
1. Teamwork within units	Staff support each other, treat each other with respect, and work together as a team
2. Supervisor/manager expectations and actions promoting safety	Supervisors/managers consider staff suggestions for improving patient safety, praise staff for following patient safety procedures, and do not overlook patient safety problems
3. Organizational learning—Continuous improvement	Mistakes have led to positive changes and changes are evaluated for effectiveness
4. Feedback and communication about error	Staff are informed about errors that happen, given feedback about changes implemented, and discuss ways to prevent errors
5. Communication openness	Staff freely speak up if they see something that may negatively affect a patient and feel free to question those with more authority
6. Nonpunitive response to error	Staff feel that their mistakes and event reports are not held against them and that mistakes are not kept in their personnel file
7. Staffing	There are enough staff to handle the workload and work hours are appropriate to provide the best care for patients
8. Management support for patient safety	Hospital management provides a work climate that promotes patient safety and shows that patient safety is a top priority
9. Teamwork across units	Hospital units cooperate and coordinate with one another to provide the best care for patients
10. Handoffs and transitions	Important patient care information is transferred across hospital units and during shift changes
11. Overall perceptions of patient safety	Procedures and systems are good at preventing errors and there is a lack of patient safety problems
12. Frequency of events reported	Mistakes of the following types are reported: (1) mistakes caught and corrected before affecting the patient, (2) mistakes with no potential to harm the patient, and (3) mistakes that could harm the patient but do not.

Send your email list to iscrclinicalsupport@facs.org

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Ongoing Collaborative Support

- National Coaching Calls
  - Second Monday at 400 PM EST (1000 AM HST until daylight savings time change)
  - Third Tuesday at 330 PM EST (930 AM HST until daylight savings time change)
- Hawaii Coaching Calls
  - Fourth Tuesday at 730 AM HST
- National Content Expert Calls
- National Ask ISCR calls
- Self-paced data training modules

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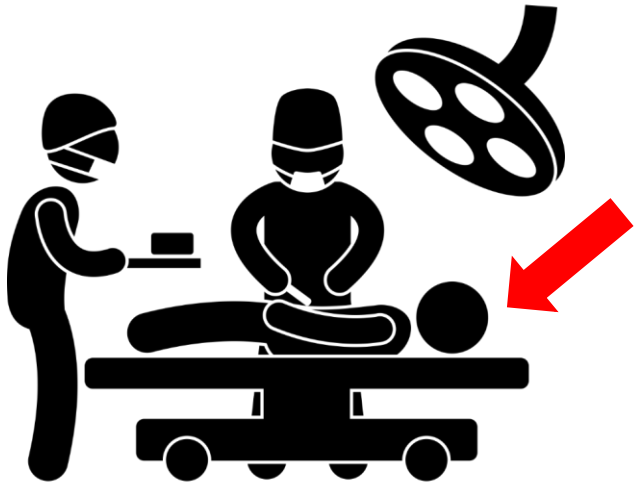
For our patients



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