High Reliability Through Decentralized Committees

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Aim

- To build and develop a successful, hospital-wide QAPI structure and process
- Ensure that service-level QAPI teams are multidisciplinary and that work is data-driven
- Identify opportunities from the data and implement timely interventions

Description

In 2003, CMS published CoPs requiring hospitals to take a proactive approach to improving the health and safety of patients by improving systems using a data-driven approach and incorporating the components of the QAPI method. This approach encompasses the identification of processes and outcomes indicators that address services provided hospital-wide. Further, the CoPs require that the hospital must measure, analyze, and track quality indicators, including adverse patient events, and other aspects of performance that assess processes of care, hospital services and operations.

Prior to 2006, VCU Health System had service-level and hospital-wide quality committees in place. However, those committees were engaging in limited objective data analysis and performance-based interventions. Thus, committee members were becoming frustrated because their perceived efforts and time spent in committees were not improving outcomes and processes.

Actions Taken

To change existing quality committees to QAPI committees, the VCU Health System utilized a structured approach:

- First, it engaged the quality committees to re-address its charter to include all necessary disciplines including physicians, nurses, social workers, infection prevention, and others as applicable.
- Second, the committee drafted annual outcomes goals and indicators to measure those goals.
- Third, the committee developed a dashboard to monitor and take action when targets were not met.
- Fourth, the committee identified adverse events by utilizing the Safety Assessment Code (SAC) matrix. Once identified, the committee performed a thorough analysis (RCA) to identify root causes, and action items.

To ensure that quality committees were converting to the new QAPI approach, each committee would present at least annually to the hospital QAPI Steering Committee, chaired by the CMO and CNO. The status of implementation was reported to the Board.

The Neurosciences QAPI was one of the first service area QAPI committees to convert to the data-driven, multidisciplinary approach. One of the first activities after formation of the charter was an adverse event analysis involving a missed EEG result that prevented a patient from receiving timely care. The process of reviewing the facts of the event, analyzing causes and implementing quality-improvement interventions improved the EEG process and helped the committee become more of a cohesive-problem-solving group.

Results

Action items from the 5-Whys analysis focused on communication and clarification of existing EEG orders within the electronic medical record.

- A new STAT EEG policy was created
- A formal communication plan for physician to physician notification of the presence of a new STAT EEG order overnight was developed
- STAT and routine EEG order strings in the electronic medical record were reviewed and amended to clarify appropriate time frames and indications for these studies

The QAPI committee continues to monitor safety reports on a monthly basis. Since the implementation of the action plan, there have been no further safety events related to EEG delays.

Summary of Results

The decentralized QAPI approach at VCU Health System has provided a mechanism and approach to address and prevent adverse events, and ensure a higher quality of care. All levels of the health system are now embracing the QAPI approach which is allowing each service to become more highly reliable by practicing consistency in delivering a high performing model of care that involves all levels and disciplines.

Lessons Learned

The journey to high reliability through decentralized committees is ongoing. It brings diverse groups together, increases morale and improves outcomes.