North Dakota Hospital Association
Innovate-ND
HRET Hospital Improvement Innovation Network

November 21, 2017

Educational Events

HRET HIIN

Rural CAH Affinity Group Virtual Event
11/27/17 | 1:00-2:00 p.m. CT

PFE Strategic Road Map Virtual Event
12/05/17 | 11:00 a.m.-12:00 p.m. CT

QI Fellowship Informational Call #1
12/08/17 | 11:00 a.m.-12:00 p.m. CT

CLABSI Virtual Event
12/14/17 | 11:00 a.m.-12:00 p.m. CT

QI Fellowship Informational Call #2
12/18/17 | 11:00 a.m.-12:00 p.m. CT

QI Fellowship Informational Call #3
1/04/18 | 11:00 a.m.-12:00 p.m. CT

QI Fellowship Informational Call #4
1/08/18 | 11:00 a.m.-12:00 p.m. CT

Information, registration links and recording links for **all** HRET HIIN upcoming and past virtual events can be found under the "Events" tab on www.hret-hiin.org.

Partner Educational Events

ND Department of Health, Disease Division | Antibiotic Stewardship in CAHs
11/21/17 | 12:00-1:00 p.m. CT

Important Dates to Remember

Remember to report your HIIN data in CDS every month!

Deadline	Reporting Period
11/27/2017	Performance data for October 2017 discharges
12/01/2017	3Q17 Hospital Activities Report in CDS

Quality Milestones Recognition

Keep an eye out for the Zero Harm Awards to be revealed in the next newsletter! Until then….drum roll!!

COPPER Milestone:
Mountrail County Medical Center

COPPER, BRONZE & SILVER Milestone:
McKenzie County Healthcare System
Sanford Hillsboro Medical Center

COPPER & BRONZE Milestone:
Ashley Medical Center
Carrington Health Center
Cavalier County Memorial Hospital
CHI Mercy Health – Valley City
CHI St. Alexius – Devils Lake
CHI Community Memorial Hospital – Turtle Lake
CHI Garrison Community Hospital
Cooperstown Medical Center
First Care Health Center – Park River
Heart of America Medical Center
Jacobson Memorial Hospital
Kenmare Community Hospital
Linton Hospital
Nelson County Health System
Northwood Deaconess Health Center
Pembina County Medical Center
Presentation Medical Center
Sakakawea Medical Center
Sanford Mayville Medical Center
Southwest Healthcare Services
St. Aloisius Medical Center
St. Andrew's Health Center
St. Luke's Hospital
Tioga Medical Center
Towner County Medical Center
Wishek Community Hospital

COPPER, BRONZE, SILVER & GOLD Milestone:

Register here.

Quality Health Associates
Antibiotic Stewardship Coaching Call
11/30/17 | 11:30 a.m.-12:30 p.m. CT
Complete details located in right column!

Quality Health Associates
QHA Infection Tracker Virtual Training
12/01/17 | 2:00-3:00 p.m. CT

Click here to join the virtual meeting.
Join the conference call:
Please call: 1-800-251-5450
Passcode: 1001919#

Click here to check your system if this is your first GoToMeeting.

NADONA
Improving Hand Hygiene in LTC and Post-Acute Care Settings
12/01/17 | 12:00–1:00 p.m. CT
Register here.

Telligen
Engaging Patients and Families as Part of the Team: Strategies for Success
12/06/17 | 12:00–1:00 p.m. CT
Register here.

PFCC Partners
Core Competencies of Effective Partners Training
1/25/18 |12:00–1:00 p.m. CT **and**
2/01/18 | 12:00–1:00 p.m. CT
RSVP here.

National Patient Safety Foundation Webcasts

The National Patient Safety Foundation (NPSF) now offers complimentary access to past NPSF webcasts. Check back often to see what is available. Visit the NPSF Webcast Archive website and follow the instructions on your screen.

Unity Medical Center	

COPPER, BRONZE, SILVER, GOLD & PLATINUM Milestone:

This holiday season we extend our appreciation to you, our colleagues and friends.
Your dedication and hard work is helping us transform healthcare locally, regionally and nationally!

Featured Resource…Infection Tracker

Quality Health Associates of North Dakota along with the ND Department of Health, Disease Division, has created an electronic Infection Tracker. This web-based tool is designed to capture patient and/or facility level HAI events, culture information and antibiotic use. A report feature allows the user to run reports and graphs. The capability to create a facility-level antibiogram is anticipated moving forward.

The Infection Tracker was originally designed to support long term care facilities with HAI collection and reporting. After expressed interest, it is being made available critical access hospitals (CAHs) as well. QHA continues to encourage CAHs to report HAI data using the CDC's HAI data repository, the National Healthcare Safety Network (NHSN); however, CAHs may find the Infection Tracker to be an adjunct to NHSN or a tool to use until their facility begins reporting data to NHSN.

Interested in exploring this more? Join us for an introduction and virtual training on December 1. Access information is provided in the left hand column of this newsletter under Partner Educational Events.

Antibiotic Stewardship

REMINDER! Antibiotic Stewardship Coaching Opportunity for ND

STRIVE Antibiotic Stewardship On-Demand Learning Modules
States **T**argeting **R**eduction in **I**nfections **v**ia **E**ngagement - STRIVE - is an infection reduction initiative rolled out by the Centers for Disease Control and Prevention (CDC) in partnership with the Health Research

RESOURCES

LISTSERV®
Sign up and help meet our goal of approximately 1,000 subscribers per LISTSERV® topic. These platforms enable peer-sharing and are used to promote virtual events and highlight innovative topic-specific strategies to reduce harm. New subscribers are added on the first day of each week.

On the Web
The HRET HIIN website is a one-stop-shop for all HRET HIIN information and events! Check it out at www.hret-hiin.org.

Social Media
Follow the HRET HIIN on Twitter @HRETtweets! Here they'll be promoting virtual events, highlighting recruitment numbers, state partners and hospitals! Re-tweet, reply or like their posts and share your HIIN journey using #WhyImHIIN.

You can also join the HRET-HIIN on Facebook and LinkedIn. Follow the instructions for joining by clicking on the correlating icon on the right-hand side of the page when you log onto

& Educational Trust (HRET) - the education arm of the American Hospital Association. STRIVE conveners have created a robust education curriculum that includes on-demand learning modules. They have very generously offered to make their Antibiotic Stewardship learning modules available to ND healthcare professionals engaged in antibiotic stewardship program implementation. While these learning modules were created with hospitals in mind, much of the information is pertinent to **all** healthcare settings.

Please join QHA's first Antibiotic Stewardship Coaching event! Here's our step-by-step plan to integrate the STRIVE modules into our AS coaching plan… our ask of you is…

1. By November 27, access and listen to the STRIVE antibiotic stewardship modules. There are 3 and each is 18-22 minutes in duration. Click here STRIVE Antibiotic Stewardship Learning Modules
2. As you listen jot down your questions, concerns, requests, suggestions and other feedback and email it to jean.roland@area-a.hcgis.org.
3. **Mark your calendars**…on November 30 from 11:30 a.m.-12:30 p.m., we'll convene for a facilitated discussion! A panel of ND antibiotic stewardship subject matter experts will join this virtual event to address your questions, give you an opportunity to share your AS experience so far, solicit dialogue among the participants, and create a true learning and action forum!

   Dial-in # (800) 251-5450 | Conference ID 100-6227 #

Antibiotic Stewardship—Reaching out to Patients and Their Families

Are you looking for Antibiotic Stewardship resources to share with your patients and their families? Check out the new Consumer Antibiotic Stewardship page on the Great Plains QIN website!

ADVERSE DRUG EVENTS

Five-Point Opioid Strategy

Last week the HRET HIIN shared an article titled, "Advancing the Practice of Pain Management Under the HHS Opioid Strategy," accessible here. This article highlights the five-point Opioid Strategy revealed by HHS in April 2017.

The strategy addresses the following components:

- Improve access to prevention, treatment, and recovery support services
- Target the availability and distribution of overdose-reversing drugs
- Strengthen public health data reporting and collection
- Support cutting-edge research
- Advance the practice of pain management

In addition, we encourage you to review AHA's recently released opioid toolkit, "Stem the Tide: Addressing the Opioid Epidemic," accessible here.

the HRET HIIN website (www.hret-hiin.org)

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HEALTH EQUITY/DIVERSITY

HSR&D Cyber Seminars – Focus on Health Equity and Action: Using Quality Improvement Projects to Demonstrate Health Equity in Action for Vulnerable Veterans – Monday, December 18, 2017 | 3:00pm – 4:00pm ET	The VA Office of Health Equity (OHE) launched the VA Health Equity Themed Quality Improvement Projects Initiative during fiscal year 2014. This initiative was launched to support local and field-based efforts to implement quality improvement efforts that have been designed or identified through existing literature and that are expected to achieve health equity and/or reduce health disparities among vulnerable Veteran groups. The purpose of the current session is to describe quality improvement projects and findings for projects funded by OHE during fiscal year 2017 and discuss lessons learned and actionable steps that can be used by VA facilities, researchers, and stakeholders to inform local and national efforts that advance health equity for vulnerable Veterans. To learn more and register, click here.
NASEM | New interactive Hub to Promote Health Equity	A new resource from the National Academies of Sciences, Engineering, and Medicine (NASEM) highlights promising community-driven approaches to advance health equity. Based on the report *Communities in Action: Pathways to Health Equity*, this interactive hub showcases examples of communities activating strategies to reduce health inequity, as well as actions and messages for the different sectors that can play a part. Click here to explore the new resource.
AHRQ | Chartbook on Rural Health Care	According to AHRQ's new Chartbook on Rural Health Care, quality of care has improved for those living in rural areas. The chartbook is part of the 2016 AHRQ National Healthcare Quality and Disparities Report, which tracks trends in effectiveness and timeliness of care, patient safety, patient-centeredness, disparities and efficiency of care. The chartbook shows that the quality of care for those living in rural areas improved for 53 percent of the measures studied. It also found that in 2014, the percentage of people who used a hospital, emergency room or clinic as a source of ongoing health care was higher for residents of rural areas compared with residents of large metropolitan areas. Between 1999 and 2015, suicide rates increased from 17 to 25 per 100,000 among whites living in rural areas and 21 to 34 per 100,000 American Indians and Alaska Natives living in rural areas.

PATIENT AND FAMILY ENGAGEMENT

Shift Report at the Bedside

Preface
This article was originally printed in The North Dakota Nurse, Nov/Dec 2017/Jan 2018 edition. We asked permission from Mayville State University and the student authors to reprint it, along with an additional paragraph regarding their experience and perspective on bedside shift report. Brent Amerud, RN, provided that addendum for us.

Appraised By
Paula Mannie, RN; Cailley Martel, RN; Brent Amerud, RN; Mayville State University RN-to-BSN students

Clinical Question

How does shift report at the bedside versus shift report at the nurses' station affect patient safety and patient care in an acute care setting?

Articles

- Maxson, P. M., Derby, K. M., Wrobleski, D. M., & Foss, D. M. (2012). Bedside nurse-to-nurse handoff promotes patient safety. MEDSURG Nursing, 21(3), 140-145.
- Tan, J.K. (2015). Review Paper. Emphasizing Caring Components in Nurse-Patient-Nurse Bedside Reporting. International Journal Of Caring Sciences, 8 (1), 188-193.
- Sand-Jecklin, K., & Sherman, J. (2014). A quantitative assessment of patient and nurse outcomes of bedside nursing report implementation. Journal Of Clinical Nursing, 23(19/20), 2854-2863.
- Agency for Healthcare Research and Quality. (2017). Nurse bedside shift report.

Synthesis of Evidence

The evidence found in our articles all supported our PICO question in that bedside report provides better patient satisfaction and safer quality care than report at a nurse's station. Our information was found through using Mayville State University's online library databases.

We also found credible webpages providing information about bedside shift report. Key search words included bedside shift report, safety of bedside report, and transforming care at the bedside (TCAB). Through these searches we were able to find valid and reliable information to support bedside report. Articles expressed how patients felt safe and that they could trust their nurses. Bedside report was also shown to have caring components. Overall the studies were shown to enhance the nurse to patient relationship. Patients and families felt more involved and included in the patient's plan of care. Bedside reporting also showed to reduce errors such as medication errors.

Bottom Line

The research concludes that bedside reporting has a higher level of professional quality and overall patient safety when conducted in a systematic fashion and includes the patient within the scope of reporting. Nurse station reporting can be beneficial to the patient and staff in terms of care planning; procedures and floor policies related to safety but also disregards a certain level of confidentiality for individual patients along with added distractors within the hospital environment.

Implications for Nursing Practice

It is found that bedside shift reporting greatly increases overall safety and communication, patient and nurse satisfaction, allows patients to trust their nurses, and decreases risk of error. Nurses should be aware that bedside reporting allows patients and their families to be involved in the plan of care, and gives them time to ask questions as needed.

Personal Experience

My experience with bedside shift reporting has been mostly positive. I began my professional nursing career in long-term care where station reporting was the given norm; it was impersonal and often overlooked subtle changes in patient behaviors through a 12- hour shift. For long-term care this was a constant struggle as the volume of patients made detailed reporting nearly impossible at times. When I left that facility to

become an RN on a medical/surgical unit there was an established protocol for bedside reporting that had been in place for approximately 6 months and it was a world of difference. My assignment of 5-6 patients was manageable so receiving a detailed report at the start of the shift filled in the gaps not covered in the patient's electronic charts. It has maintained privacy for the patient under HIPPA, helped establish consistent communication with their care teams as well as the nurse/patient relationship which I feel suffers under abrupt assignment changes. If family is present, then they are included within this report and have the most up to date information available; this is also true at times when they may call to inquire on a loved one's condition immediately at the start of a shift.

There have been a few instances where bedside reporting hasn't been convenient or in the best interest of the patient. Language is often ambiguous especially when referring to patient behaviors, so often, information can be incorrect in this regard. Patients may contest this as a report is given in front of them, leading to tension with their oncoming nurse. Hourly rounding, repositioning and routine checks chip away at a patient's sleep/rest cycle so bedside report

CLINICAL GUIDELINES UPDATE

2017 Hypertension Guidelines

High blood pressure accounts for the second largest number of preventable heart disease and stroke deaths, second only to smoking. It's known as the "silent killer" because often there are no symptoms, despite its role in significantly increasing the risk for heart disease and stroke.

Last week the American Heart Association released the 2017 Hypertension Clinical Guidelines

- This guideline is an update of the National Heart, Lung, and Blood Institute publication, "The Seventh Report of the Joint National Committee on Prevention, Detection, Evaluation and Treatment of High Blood Pressure" (JNC 7) and is a comprehensive resource for the clinical and public health practice communities.
- Previous guidelines identified high blood pressure as ≥ 140/90 mm Hg. This guideline now defines high blood pressure to be anyone with a systolic blood pressure (SBP) ≥ 130 mm Hg or diastolic blood pressure (DBP) ≥ 80 mm Hg.
- The change will mean more patients are diagnosed with hypertension. To improve blood pressure control and reduce cardiovascular disease (CVD) risk in these patients, a small percentage of them will be asked to take medications while the majority will be recommended for nonpharmacological interventions with healthy lifestyle changes.

Following are the four new Blood Pressure categories based on the average of two or more in-office blood pressure readings.

Normal: < 120 mm Hg Systolic BP (SBP) and < 80 mm Hg Diastolic BP (DBP)
Elevated: 120-129 mm Hg SBP and < 80 mm Hg DBP
Stage 1 Hypertension: 130-139 mm Hg SBP or 80-89 mm Hg DBP and

Stage 2 Hypertension: ≥ 140 mm Hg SBP or ≥ 90 mm Hg DBP

Read the complete guideline.

READMISSIONS

Noncompliance

By Pat Teske

It is frustrating to see patients for whom we've developed a discharge plan return to the hospital. Often, we assume that the reason the patient returned was a lack of compliance on their part. While this kind of thinking may make us feel better, it is flawed. Although some patients present more daunting challenges than others when we label them as non-compliant we may do so not understanding the barriers they may be facing. Health literacy is often involved. Here are signs of health literacy which we sometimes misinterpret as non-compliance:

- Frequently missed appointments
- Incomplete registration forms
- Not taking medications or not taking medications as prescribed
- Unable to name medications, explain purpose or dosing
- Identifies pills by looking at them, not reading label
- Unable to give coherent, sequential history
- Ask fewer questions
- Lack of follow-through on tests or referrals

Instead of claiming our patients as non-compliant we need to truly understand the reasons for their readmission. We must eliminate the notion of non-compliance a dig deeper to learn the root cause of readmissions. Here's what we can do:

- Routinely interview readmitted patients to learn what happened between the day of discharge and the point at which they (or someone else) decided they needed to return to the ED.
- Use your insights from readmission interviews to improve care for that patient.
- Use your collective insights from all interviews to identify high-leverage improvement ideas.

We can better engage our patients by using tool such as the CMS discharge planning checklist that invite patients and their caregivers to co-develop their discharge plans. When it comes to patient education, we must identify the learner and focus on "need-to-know" & "need-to-do" items. We need to use the teach-back method to validate understanding prior to discharge and use clearly written education materials. We can demonstrate, draw pictures, and simulate the desired activity such as getting up on a scale and recording weight. Most importantly we need to understand the patient's goals. What matters to them, not what's the matter with them.

Let's stop blaming our patients and dive deeper to reduce readmissions.

Social Determinants of Health: Transportation and the Role of Hospitals

Every year, 3.6 million people in the U.S. do not obtain medical care due to transportation issues. Transportation issues, which affect rural and urban communities, may result in missed or delayed health care appointments, increased health expenditures and overall poorer health outcomes.

A recent guide published by AHA, "Transportation and the Role of Hospitals," discusses how transportation issues affect health and health care access and outlines strategies for hospitals and health systems, including screening and evaluating patients' transportation needs and providing transportation services through community partnerships or programs. Transportation also can be a vehicle for wellness as reliable and safe transportation options are essential for healthy communities. This guide highlights initiatives at four hospitals and health care systems—CalvertHealth Medical Center, Denver Health Medical Center, Grace Cottage Family Health & Hospital and Taylor Regional Hospital —that are addressing transportation issues in their communities.

This guide is part of a series of resources released by the AHA, HRET and ACHI on how hospitals can address the social determinants of health.

Access the guide at www.aha.org/transportation.