Hospital Quality Measures	CMS HRI	JCAHO
Acute Myocardial Infarction (AMI)		
Aspirin within 24 hours before or after arrival if no contraindications	x	x
Aspirin prescribed at discharge if no contraindications	x	x
ACE Inhibitor for left ventricular systolic dysfunction if no contraindications	x	x
Smoking cessation advice or counseling for patients with a history of smoking within the past year.	x	x
Beta Blocker at discharge if no contraindications	x	x
Beta Blocker within 24 hours after arrival if no contraindications	x	x
Median time from arrival to administration of a thrombolytic agent, if indicated based on ECG performed closest to the arrival time.	x	x
Primary thrombolytic therapy within 30 minutes of arrival	x	x
Median time to PTCA (not done here)	x	x
PTCA received within 90 minutes of hospital arrival (not done here)	x	**
Inpatient mortality		x
** JCAHO Planned Implementation		

Hospital Quality Measures	CMS HRI	JCAHO
Heart Failure (HF)		
Written discharge instructions or educational material for patient or caregiver upon discharge covering 6 required areas: medications, diet/fluid intake, activity level, follow-up appointment, weight monitoring, and what to do when symptoms worsen	x	x
Documentation of left ventricular function assessment before during or planned for after discharge	x	x
ACE Inhibitor prescibed at discharge for left ventricular dysfunction if no indications	x	x
Smoking cessation advice or counseling for patients with a history of smoking within the past year.	x	x
** JCAHO Planned Implementation		

CMS - Center for Medicare Services

HRI - National Voluntary Reporting Initiative (HRI)Measures launched by AHA, (American Hospital Association), FAH, (Federal Association of Hospitals and AAMC (American Association of Medical Colleges)

JCAHO - Joint Commission for the Accreditation of Healthcare Organizations

Hospital Quality Measures

	CMS HRI	JCAHO
Pneumonia (PNE)	x	**
First dose of antibiotic received within 4 hours of arrival	x	x
Median time to first antibiotic dose	x	**
Immunocompetent patients who receive intial antibiotic selection consistent with the current guidelines during the first 24 hours	x	x
Blood culture specimen collected prior to the first hospital dose of antibioticsl	x	x
Initial hospital blood culture specimen collected prior to the first hospital dose of antibiotics	x	x
Screening for influenza vaccine status and vaccination prior to discharge, if indicated - patients age 50 and olderd during October - February	x	x
Screening for pneumococcal vaccine status and vaccination prior to discharge, if indicated - patients 65 years and older	x	x
Smoking cessation advice or counseling for patients with a history of smoking within the past year.		x
Assessment of arterial oxygenation by arterial blood gas or pulse oximetry within 24 hours prior to or after arrival	x	x

Hospital Quality Measures

	CMS HRI	JCAHO
Surgical Infection Prevention	x	**
Prophylactic antibiotic received within 1 hour to surgical incision (2 hours for Vancomycin)	x	**
Prophylactic antibiotics consistent with current guidelines (specific to each type of surgical procedure)	x	**
Prophylactics antibiotics discontinued within 24 hours after surgery end time		
** JCAHO Planned Implementation		

National Patient Safety Goals	2005		2006	National Patient Safety Goals	
		Actions Taken			**Actions Taken and Planned**
Goal 1. Improve the accuracy of patient identification				**Goal 1. Improve the accuracy of patient identification**	
1a. Use at least two patient identifiers (neither of which is to be the patient's room number) whenever administering medications of blood products or taking blood samples or other specimens for clinical testing **or providing any other treatment or procedures.**		Identification is done by checking the ID band and asking the patient his name and birthdate. If there are patients with same or similar names, a "Name Alert" sticker is placed on the chart and the Kardex.		1a. Use at least two patient identifiers (neither of which is to be the patient's room number) whenever administering medications of blood products or taking blood samples or other specimens for clinical testing **or providing any other treatment of procedures.**	Identification is done by checking the ID band and asking the patient his name and birthdate. If there are patients with same or similar names, a "Name Alert" sticker is placed on the chart and the Kardex. PLANNED: For procedures out side of the OR, done at the bedside, need to have a "time out" to be certain that we have the correct patient, the correct site and the correct procedure. Any variations will be reported. Prcedure was rewritten in 7/05.
Goal 2. Improve the effectiveness of communication among care givers.					
2a. For verbal orders or telephone orders, or telephonic reporting of critical lab results, verify the complete order or test result, by having the person receiving the order or test result read-back the complete order or test result		**Verbal orders are to be used only in an emergency.** Telephone and verbal orders are jotted down then read-back to the originator of the order, recorded in the medical record with the physician and nurses name with the initial "TORB" or VORB" to indicate the telephone or verbal order has been read back. When lab results are called to a provider, the name of the person to whom they were given, the date and time of the call and the lidentities of the persons involved in the are recorded in the EMR. This process is being monitored by the nurse managers.		2a. For verbal orders or telephone orders, or telephonic reporting of critical lab results, verify the complete order or test result, by having the person receiving the order or test result read-back the complete order or test result	**Verbal orders are to be used only in an emergency.** Telephone and verbal orders are jotted down then read-back to the originator of the order, recorded in the medical record with the physician and nurses name with the initial "TORB" or VORB" to indicate the telephone or verbal order has been read back. When lab results are called to a provider, the name of the person to whom they were given, the date and time of the call and the lidentities of the persons involved in the are recorded in the EMR. This process is being monitored by the nurse managers.

National Patient Safety Goals	2005		2006	National Patient Safety Goals	
		Actions Taken			Actions Taken and Planned
2b. Standardize a list of abbreviations, acronyms and symbols that are not to be used throughout the organization.		Abbreviations, acronyms, and symbols that are not be be used have been publicized and monitoring is being done by the Pharmacy. Overall rate is acceptable, but individual physicians need specific improvement. Individual physicians are getting feedback.		2b. Standardize a list of abbreviations, acronyms and symbols that are not to be used throughout the organization.	Continue to monitor and provide feedback. Posters will be hung. Expect improvement.
				2e. **Implement a standardized approach to "hand-off" communications, including an opportunity to ask and respond to questions.**	Staff will be trained in the SBAR method of communication (Situation, Background, Assessment, and Recommendations) to standardize communication
Goal 3. Improve the safety of using medications.				**Goal 3. Improve the safety of using medications.**	
3a. Remove concentrated electrolytes (including, but not limited to potassium chloride, potassium phosphate and sodium chloride greater than 0.9%) from patient care units.		None of the concentrated electrolytes are available on the patient care units		Retired in 2006	
3b. Standardize and limit the number of drug concentrations available in the organization.		Drug concentrations have been standardized and limited.		3b. Standardize and limit the number of drug concentrations available in the organization.	Drug concentrations have been standardized and limited.
3c. **Identify and, at a minimum, annually review list of look-alike/sound alike drugs used in the organization, and take action to prevent errors involving the interchange of these drugs.**		Look-alike, sound-alike medicines are identified in the PYXIS by TALL man lettering.		3c. Identify and, at a minimum, annually review list of look-alike/sound alike drugs used in the organization, and take action to prevent errors involving the interchange of these drugs.	Look-alike, sound-alike medicines are identified in the PYXIS by TALL man lettering. 10 medicaitions were chosen from our formulary as the most likely to be problem prone. List approved by P&T Committee 7/26/05. **Those chosen were: Oral Morphine liquids Roxanol and MSIR; Fentanyl and Sufentanil, Sublimaze and Sufenta; Hydromorphone and Morphine, Dilaudid and Morphine; All insulin products; Doxil and Dunoxome, both lipid based products; Lipid based vs. conventionally based Amphotericin, Ambisome, Abelcet, Amphotec; Avandia and Coumadin that are subject to handwriting problems; Celbrex, Celexa and Cerebryx; Clonidine (Catapres) and Clonazepam (Klonopin) and Zyprexa and Zyrtec.**
				3d. **Label all medications, medication containers, (e.g. syringes, medicine cups and basins) or other solutions on and off the sterile field in perioperative and other procedural settings.**	Labels have been ordered for both medicaitons and fluids that could be on the OR worktable.

National Patient Safety Goals	2005		2006	National Patient Safety Goals	
		Actions Taken			Actions Taken and Planned
Goal 4. Improve the safety of using infusion pumps				**Goal 4. Improve the safety of using infusion pumps**	
4a. Ensure free-flow protection on all general use and PCA (patient-controlled analgesia) intravenous infusion pumps used in organizations.		General use and PCA (Patient Controlled Analgesia) intravenous infusion pumps have free flow protection.		Retired in 2006	PCA Pumps are being replaced with new ones that have the SMART Technology and will be programmed for Dilaudid and Fentanyl that are used the most often. This will address maximum dose issues.
Goal 7. Reduce the risk of health care-associated infections				**Goal 7. Reduce the risk of health care-associated infections**	
7a. Comply with current Center for Disease Control and Prevention (CDC) hand hygiene guidelines		Staff has been trained that handwashing should be done for a minimum of 15 seconds, but that it is more effective to use alcohol-based hand cleaner if hands are not grossly soiled. There has been some discussion about the flammability of the alcohol-based hand cleaner, but if stored in appropriate size containers, the benefit is greater than the risk. The Fire Marshal needs to get up to speed with this.		7a. Comply with current Center for Disease Control and Prevention (CDC) hand hygiene guidelines	Monitoring of the patients' perception of whether or not the health care provider cleaned their hands prior to care is being done on the Press Ganey report. Use of these and other patient safety questions started in April, 2005.
7b. Manage as a sentinel event all identified cases of unanticipated death or major permanent loss of function associated with a health care-acquired infection.		There have been no infections that resulted in death or major permanent loss of function that were not attributable to the patient's disease course.		7b. Manage as a sentinel event all identified cases of unanticipated death or major permanent loss of function associated with a health care-acquired infection.	Continue to review any deaths in which an infection is involved.

National Patient Safety Goals	2005		2006	National Patient Safety Goals	
		Actions Taken			Actions Taken and Planned
Goal 8. Accurately and completely reconcile medications across the continuum of care.				**Goal 8. Accurately and completely reconcile medications across the continuum of care.**	
8a. **During 2005, for full implementation by January, 2006, develop a process for obtaining and documenting a complete list of the patient's current medications upon admission to the organization and with the involvement of the patient. This process includes a comparison of the medications the organization provides to those on the list.**		**On admission**: A list of medications take at home by the patient is taken during the admission history and assessment. The home list is printed out and put under a special tab in the record for the physician tor review.		**8a. Implement a process for obtaining and documenting a complete list of the patient's current medications upon the patient's admission to the organization and with the involvement of the patient. This process includes a comparison of the medications the organization provides to those on the list.**	Auditing needs to be done at each level to see the gaps in communication. This needs to be done in the outpatient arena, e.g. ER to reconcile the medications as they are taken and to address any follow-up with the follow-up health care provider.
		Transfers between levels of care: A medication profile can be printed for the physician to review when the patient is moved from one level of care to another. The physician makes notations on the list and signs the copy and it becomes an order which is faxed to the pharmacy. At Discharge: Discharges to home receive discharge instructions with a medication list only completed by the unit secretary/team leader/discharging nurse. Discharges to other levels of care have a standardized form completed that lists all medications, treatments, diet, etc.completed by the Discharge Planner and signed by the physician. The Discharge DIG has redesigned the discharge instruction sheet so that it is individualized for each patient.			
8b. **A complete list of the patient's medications is communicated to the next provider of service when it refers or transfers a patient to another setting, service, practitioner or level of care within or outside the organization.**	X	**On admission**: A list of medications take at home by the patient is taken during the admission history and assessment. The home list is printed out and put under a special tab in the record for the physician tor review. **Transfers between levels of care:** A medication profile can be printed for the physician to review when the patient is moved from one level of care to another. The physician makes notations on the list and signs the copy and it becomes an order which is faxed to the pharmacy. **At Discharge:** Discharges to home receive discharge instructions with a medication list only completed by the unit secretary/team leader/discharging nurse. Discharges to other levels of care have a standardized form completed that lists all medications, treatments, diet, etc.completed by the Discharge Planner and signed by the physician. The Discharge DIG has redesigned the discharge instruction sheet so that it is individualized for each patient.		**A complete list of the patient's medications is communicated to the next provider when the patient is referred or transferred to another setting, service, practitioner or level of care within or outside the organization.**	Auditing needs to be done at each level to see the gaps in communication.

National Patient Safety Goals	2005		2006	National Patient Safety Goals	
		Actions Taken			Actions Taken and Planned
Goal 9. Reduce the risk of patient harm resulting from falls.				**Goal 9. Reduce the risk of patient harm resulting from falls.**	
9a. **Assess and periodically reassess each patient's risk for falling, including the potential risk associated with the patient's medication regimen and take action to address any identified risks.**		There is a fall risk assessment done on admission, but the reassesment time frame was not defined. Improved assessment is now available with interventions tied to the score of the assessment. Patients are to be assessed at least each shift or more often depending upon findings.		Replaced by 9 b	
				9b. Implement a fall reduction program and evaluate the effectiveness of the program.	Fall Program developed with new assessment tools related to interventions. To be "rolled out" 8/16/05. Use data to determine that interventions result in fall prevention by decreasing the falls per 1000 patient days.

National Patient Safety Goals	2004	2005	Actions Taken
Goal 8. Accurately and completely reconcile medications across the continuum of care.		X	See below:
8a. **During 2005, for full implementation by January, 2006, develop a process for obtaining and documenting a complete list of the patient's current medications upon admission to the organization and with the involvement of the patient. This process includes a comparison of the medications the organization provides to those on the list.**		X	We currently document the patient's medications, but often the list that the ER nurse, ER physician, admitting nurse and patient's Primary Care Provider do not agree. This will be a problematic goal to accomplish. It will take a team approach.
8b. **A complete list of the patient's medications is communicated to the next provider of service when it refers or transfers a patient to another setting, service, practitioner or level of care within or outside the organization.**		X	To Be Addressed.