2011 Annual Report
Celebrating 2010 Accomplishments

Quality, Patient Safety, and Performance Improvement

BUFFALO HOSPITAL
Allina Hospitals & Clinics

Building a Culture of Excellence and Safety at Buffalo Hospital

2010 was a year of great strides at Buffalo Hospital. Overall quality, patient safety, patient experience and performance improvement outcomes demonstrated a culture dedicated to achieving and sustaining excellence.

Buffalo Hospital is committed to transparency and to meeting the needs and expectations of our patients. Sharing performance results empowers patients, staff, leaders and stakeholders to make informed health care choices. To improve, we have to measure. This report reflects the enormous effort that goes into measurement and serves as a means of conveying the organization's accomplishments in key areas.

In addition to the information provided in this annual report, the organization realized the following significant accomplishments in 2010:

- Thomson Reuters recognized Buffalo Hospital as one of the nation's Top 100 Hospitals. Buffalo Hospital was also one of 23 hospitals honored with the Everest Award, which recognizes both the highest current performance and the fastest long-term improvement over five years.
- The Minnesota Department of Health designated the Buffalo Hospital Emergency Department as a Level III Trauma center.
- Staff were recognized by the Minnesota Hospital Association's "Good Catch for Safety" award for their diligent efforts in identifying significant patient safety opportunities for improvement.
- Allina recognized both the Birth Center and Med-Surg for their significant improvements in Patient Experience as demonstrated with significant improvement in HCAHPS scores.
- The American Association of Blood Banks surveyed and accredited the hospital laboratory for another two years.
- The Minnesota Board of Pharmacy conducted an unannounced survey and inspection of the Buffalo Hospital pharmacy in September of 2010 with no significant findings.

The quality, safety and service work completed in 2010 serves as a strong foundation for the strategic initiatives which lie ahead in 2011. This work is representative of a comprehensive quality and safety program which encompasses the organization through the efforts of physicians, staff and leaders. As we celebrate our 2010 accomplishments, we also recognize that we need to continually strive to meet the needs of our patients and improve outcomes of care.

Gretchen Frederick, RN, MA
Director of Patient Care
Buffalo Hospital

Corey Martin, MD
Director of Medical Affairs
Buffalo Hospital

Table of Contents

Quality and Patient Safety Scorecard

CARE: Core Measures & Readmission Reduction	2010 GOAL	1ST QTR 2010	2ND QTR 2010	3RD QTR 2010	4TH QTR 2010
Acute Myocardial Infarction (AMI) Optimal Care	95%	100%	100%	100%	No pts
Congestive Heart Failure (CHF) Optimal Care	95%	92%	94%	100%	100%
Pneumonia (PN) Optimal Care	95%	96%	89%	82%	92%
Surgical Care Improvement Project (SCIP) Optimal Care	90%	96%	97%	99%	92%
Outpatient SCIP	95%	100%	100%	100%	92%
Outpatient AMI - ASA on Arrival	95%	100%	100%	100%	95%
Outpatient AMI - Median Time to EKG	10 mins	10 mins	10 mins	9 mins	6 mins
Heart Failure Re-admission Rate	< 17%	13.3%	33.3%	40.0%	23.1%
Pneumonia Re-admission Rate	< 14%	7.7%	16.7%	20.0%	3.7%
AMI re-admission Rate	< 10.6%	0%	100%	50%	No pts
Inpatient mortality rate per 100 IP discharges	0.60	0.70	0.65	0.48	0.51

SERVICE: Patient Experience	2010 GOAL	1ST QTR 2010	2ND QTR 2010	3RD QTR 2010	4TH QTR 2010
Patient Experience - Inpatients rating BH a 9 or 10	64%	61.1%	69.2%	73.9%	69.0%
Patient Experience - Outpatient Overall % Excellent	51.0%	50.0%	49.5%	51.0%	51.2%
Patient Experience - Pain Management Score	71.9%	67.3%	73.8%	72.1%	69.2%
Patient Experience - Physician Communication Score	85.2%	79.8%	81.7%	81.4%	77.2%
Grievances - Inpatient (Rate per 1000 adjusted pt. days)	< 1.00	0	0	0	0
Grievances - Emergency Department (Rate per 1000 ED visits)	< 3.50	1.17	0.55	0.70	0.74

SAFETY	2010 GOAL	1ST QTR 2010	2ND QTR 2010	3RD QTR 2010	4TH QTR 2010
Falls: Falls Rate (overall) per 1000 IP days	< 2.65	1.82	1.26	2.51	2.48
Falls: Harmful falls rate per 1000 IP days	< 1.13	0.61	0	0	0.62
Hand Hygiene – Room Entry	> 90%	83.7%	72.1%	80.2%	81.4%
Hand Hygiene – Room Exit	> 90%	89.5%	72.2%	80.0%	80.4%
Hospital acquired C-Diff rate per 10,000 inpatient days	12.66	0	1.26	0	0
Medication error rate (overall) per 1000 doses charged		0.26	0.61	0.53	0.48
Adverse Health Events	0	0	0	0	1

Core Measures Optimal Care

Acute Myocardial Infarction Optimal Care

Heart Failure Optimal Care
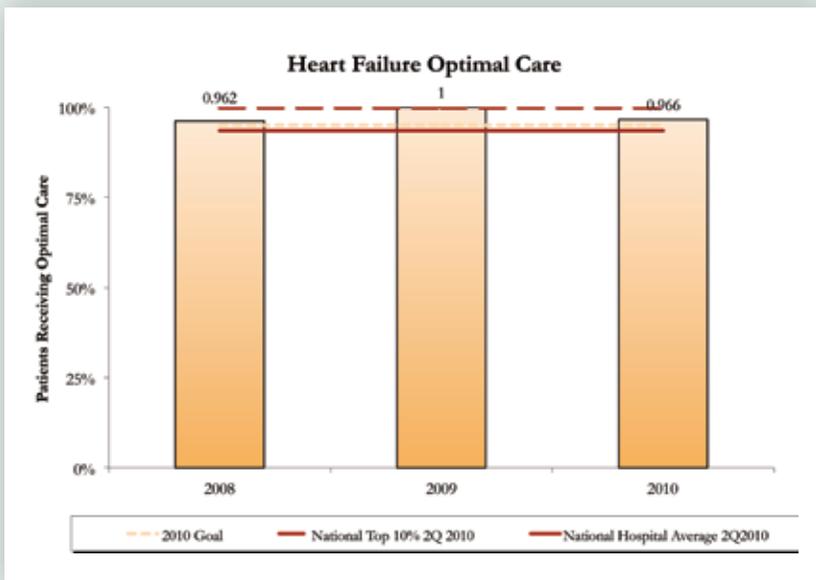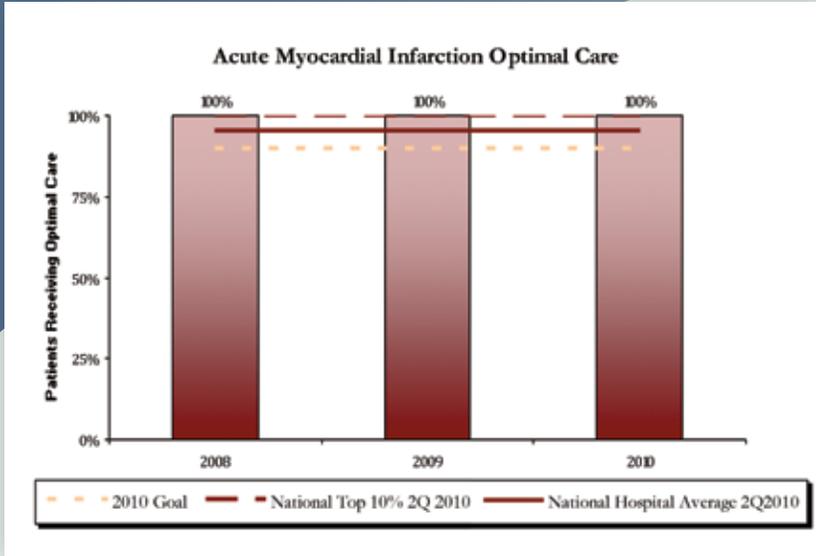
Measure: Acute Myocardial Infarction (AMI), Heart Failure and Pneumonia Optimal Care

Definitions: *Core Measures-* A uniform set of measures based on best practice guidelines which are nationally accepted standards of care across all hospitals. *Optimal Care-* Percent of patients receiving all interventions appropriate to their care.

Inclusions: Inpatients with a principal discharge diagnosis of AMI, Heart Failure, or Pneumonia as defined by the Centers for Medicare and Medicaid Services (CMS).
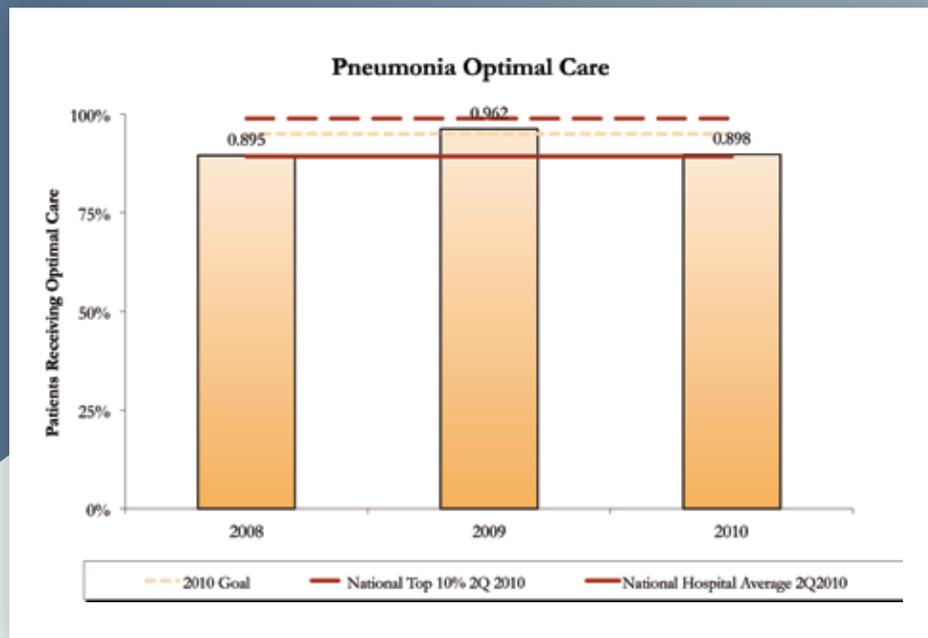
Exclusions: Outpatients with the same diagnoses; patients <18 years of age, and other measure-specific exclusions as defined by CMS.

Goal: Overall average optimal care score of 95% for AMI, Heart Failure and Pneumonia combined.

Data Source: Medstat Database; QIWA Reports

Summary: The optimal care goal for 2010 was met 2/4 quarters in 2010. The overall end of year average was met at 95%. Core measures are challenging due to unpredictable, often low volumes. Concurrent case monitoring with real time feedback/education to nurses and physicians was sustained. The Quality Department and MedSurg/SCU Patient Care Supervisor work together as a team to assure a seamless process for ongoing core measure compliance.

Pneumonia Optimal Care

Chart: "Pneumonia Optimal Care" showing bars for years 2008 (0.895), 2009 (0.962), and 2010 (0.898). Y-axis: Patients Receiving Optimal Care (0% to 100%). Legend: 2010 Goal, National Top 10% 2Q 2010, National Hospital Average 2Q2010.
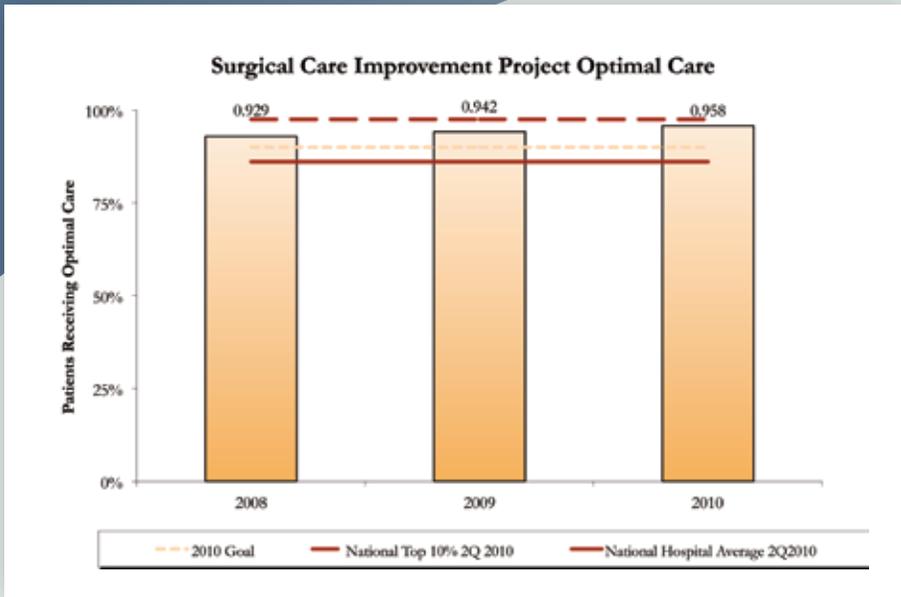
Data was shared on a quarterly basis with staff, hospital leadership, medical staff committees, and the Board of Directors. The core measure leads participated in regularly scheduled Allina meetings/conference calls, implementing best practices based on Allina system tests of change.

Core measures will remain an Allina and Buffalo Hospital strategic goal in 2011. Efforts will be focused on sustaining 2010 achievement. Additional core measures work planned for 2011:
- Increase use of standardized core measure order sets.
- Addition of Pediatric Asthma Core Measures.
- Plan for retirement of pneumonia immunization measures with addition of a global immunization measure set in 2012.

Leads: Val Enter/Amanda Duerr

Surgical Care Improvement Project Optimal Care

Surgical Care Improvement Project Optimal Care

0.929   0.942   0.958

2008   2009   2010

--- 2010 Goal   —— National Top 10% 2Q 2010   —— National Hospital Average 2Q2010

Measure: Surgical Care Improvement Project (SCIP) Optimal Care

Definitions: *Core Measures-* A uniform set of measures based on best practice guidelines which are nationally accepted standards of care across all hospitals. *Optimal Care-* Percent of patients receiving all interventions appropriate to their care.

Inclusions: Antibiotic administration timing prior to incision, appropriate antibiotic selection, and timely discontinuation of antibiotic (for surgical case types: hip and knee arthroplasty, colon resection, and abdominal/vaginal hysterectomy); hair removal, beta blocker administration for patients on beta-blockers at home, VTE prophylaxis, urinary catheter removal and perioperative temperature management for selected surgical populations.

Exclusions: Surgical procedures other than those identified above.

Goal: 90%

Data Source: Medstat Database; QIWA Reports

Summary: The SCIP optimal care goal was exceeded in all four quarters in 2010, with an overall end of year score of 96%. Compliance sustainment is attributed to concurrent case monitoring with real time feedback to nurses and physicians. In addition, Excellian order set changes, Best Practice Alerts (BPA's), and flow sheet redesign have been ongoing work to support care providers in attaining the goal.

The SCIP score for 2011 will be compiled with the heart failure, pneumonia and acute myocardial infection measures. The overall optimal care goal for all four core measures will be 95%.

Leads: Val Enter, Amanda Duerr, Jill Bjornson

Outpatient Acute Myocardial Infarction Core Measures

Outpatient Core Measure Aspirin on Arrival

Outpatient Core Measure Median Time (minutes) to ECG

↓ is good
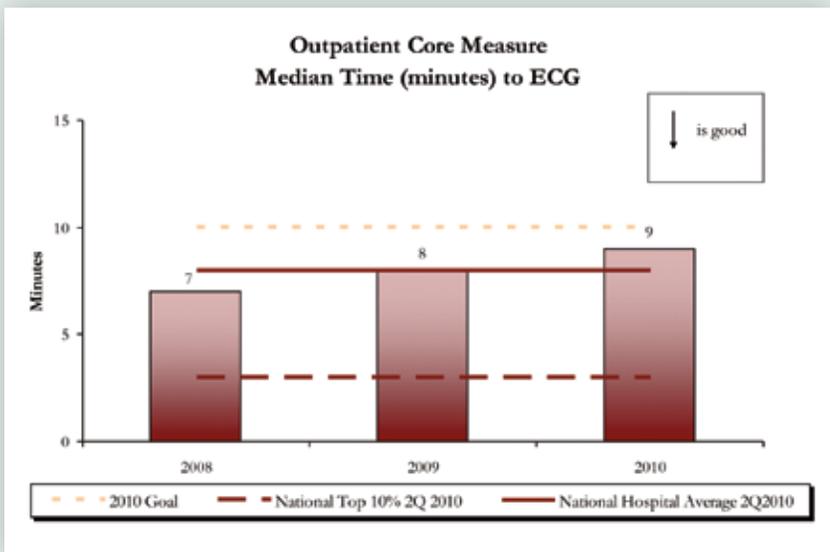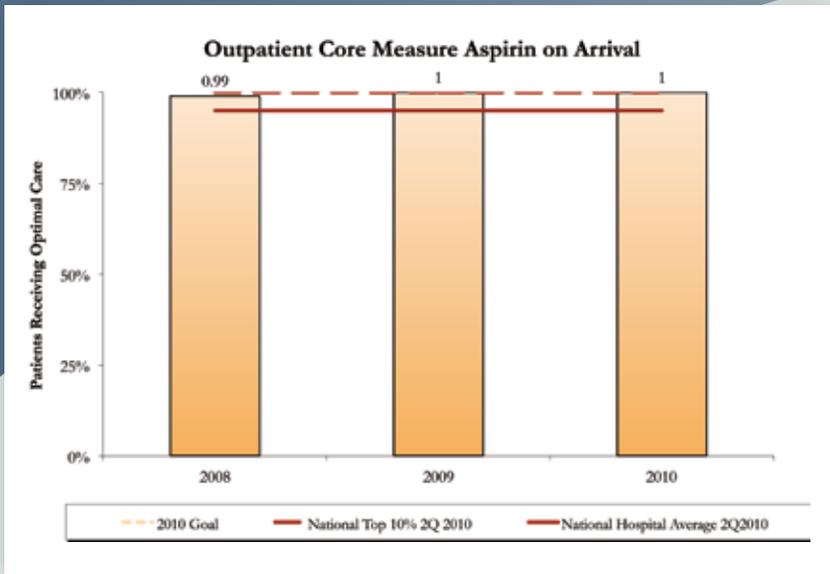
Measure: Outpatient Core Measures - AMI

Inclusions: AMI/Chest Pain- Patients presenting to the Emergency Department (ED) with chest pain and acute myocardial infarction (AMI) who are not admitted for inpatient care. The chest pain measure is a sample of all chest pain patients.

Exclusions: AMI

Goals: 95% points with AMI/Chest receive ASA on arrival, Median time to ECG < 10 minutes.

Data source: Medstat Database; QIWA Reports

Summary: The majority of Buffalo Hospital AMI patients are cared for in the outpatient setting (ED) rather than inpatient units. These patients are commonly transferred to a facility with cardiac specialists from the ED. A large number of chest pain patients are also seen in the ED. The outpatient core measures are indicators of adherence to evidence-based practice for this patient population. Compliance with outpatient core measures for AMI/chest pain is 98.6% for aspirin in chest pain patients, 100% for aspirin in AMI patients and 9 minutes for median time to EKG.

2010 quality improvement efforts focused on sustaining compliance with best practice care with focus on aspirin administration on arrival.

2011 quality improvement efforts will focus on sustaining and improving measure compliance:
• Improve median time to ECG time to less than National Benchmark of nine minutes.
• Improve documentation compliance for AMI/CP patients who have non-cardiac source of chest pain.

Leads: Val Enter/Margo Binsfeld

Outpatient SCIP Core Measures

Outpatient Core Measure Antibiotic Selection

Outpatient Core Measure Antibiotic Timing
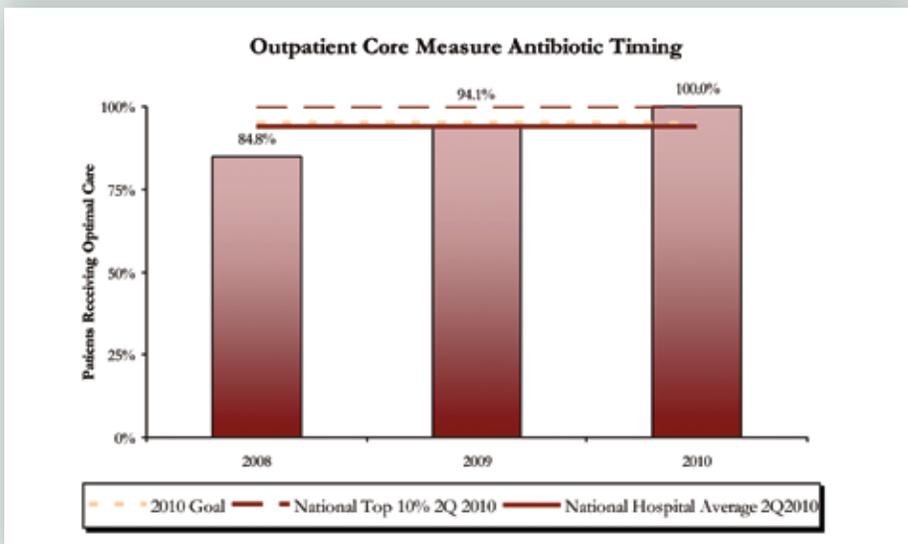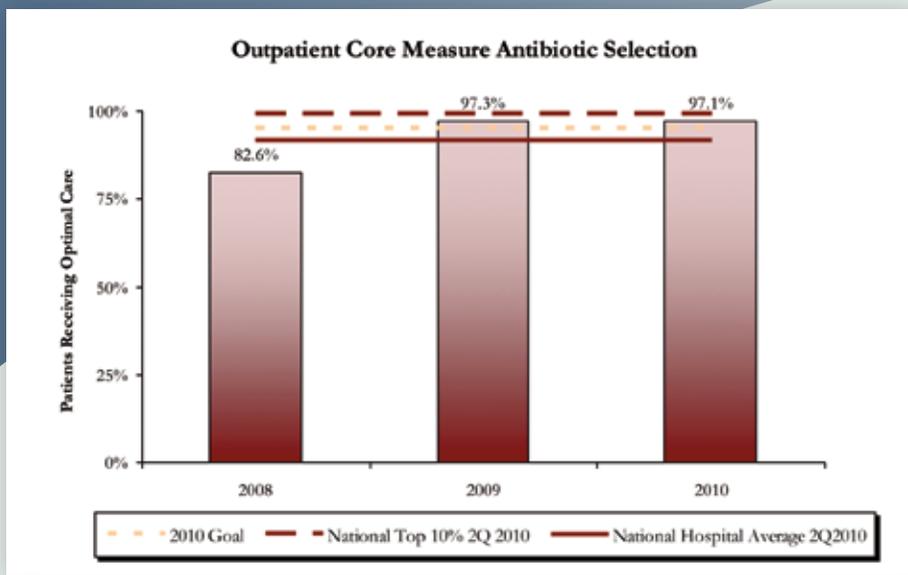
Measure: Outpatient Core Measures-SCIP

Inclusions: Outpatient surgical procedures (sample of all outpatient procedures)

**Exclusions:** Inpatient surgical procedures

Goals: 95% antibiotics administered within 1 hour of incision time, 95% appropriate antibiotics ordered

Data Source: Medstat Database; QIWA Reports

Summary: Outpatient SCIP includes select surgical procedures performed on an outpatient basis. The same inpatient procedure antibiotic measures for selection and timing are applied to these outpatient procedures. The goal of 95% was met for 3/4 quarters in 2010, with an overall compliance of 98%. Strategies used for inpatient core measures were applied across outpatient procedures.

Leads: Val Enter, Jill Bjornson

Stroke Optimal Care

Stroke Optimal Care
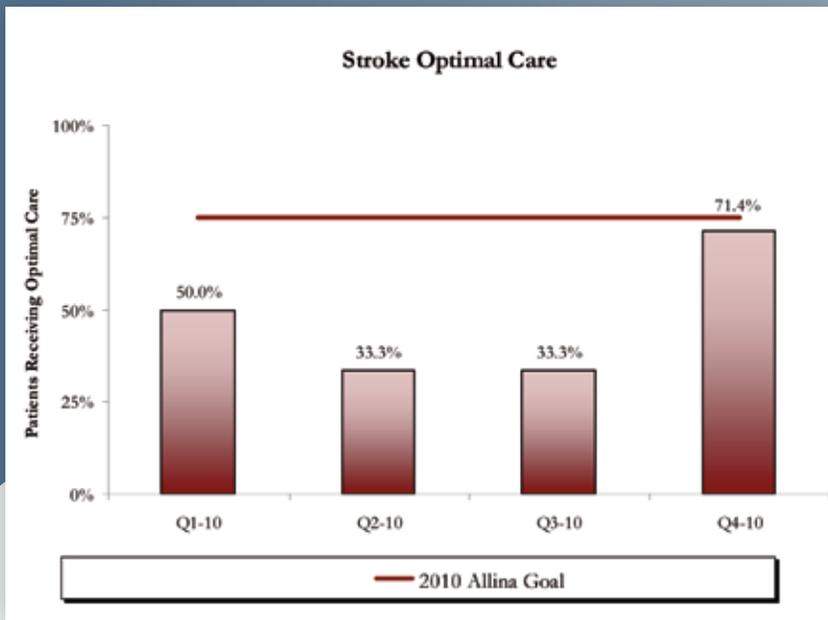
Measure: Stroke Optimal Care

Definitions: *Core Measures-* A uniform set of measures based on best practice guidelines which are nationally accepted standards of care across all hospitals. *Optimal Care-* Percent of patients receiving all interventions appropriate to their care.

Inclusions: Inpatients with a principal discharge diagnosis of ischemic or hemorrhagic stroke as defined by the Centers for Medicare and Medicaid Services (CMS).

Exclusions: Outpatients with the same diagnoses; patients <18 years of age, and other measure-specific exclusions as defined by CMS.

Goals: 75%

Data Source: Outcome Science Database; QIWA Reports

Summary: A new measure set containing eight CMS stroke core measures was introduced in 2010. A system Stroke Core Measures Team was launched with active site lead participation in stroke education,

identification of core measure failure trends, and Excellian support enhancements. In addition, a multidisciplinary site-based Stroke Core Measures team was initiated.

Mandatory stroke education was provided to nursing staff. Physicians also received stroke core measure education through department meetings and were encouraged to use Allina stroke admission order sets to promote best practice and core measure compliance. Patient volumes for this measure set are small as most of these patients are transferred to a facility with neurology. Although the year-end optimal care goal was not met at 52.6%, stroke optimal care scores improved dramatically over the course of the year from 33% in 2nd quarter to 71.4% in 4th quarter. Additional stroke core measures work planned for 2011:

- Sustain and surpass the substantial gains achieved in stroke core measures optimal care in 2010. The Allina stroke core measures optimal care goal has increased to 85%.
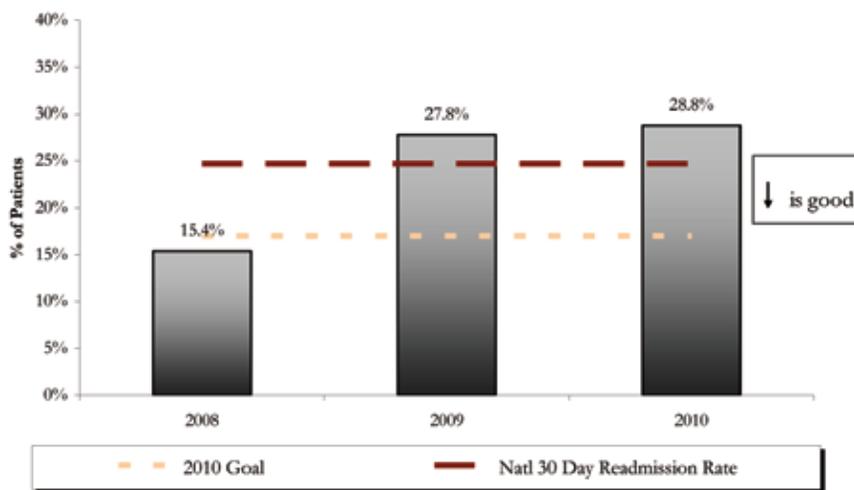
Leads: Katie Roers, Amanda Duerr and Stroke Core Measure Team

Readmission Reduction

Acute Myocardial Infarction 30 Day Readmission Rate
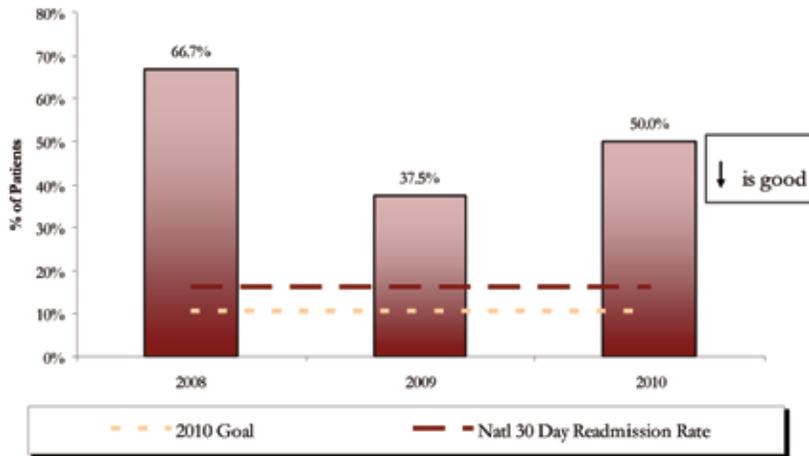
Heart Failure 30 Day Readmission Rate

Measure: Acute Myocardial Infarction (AMI), Heart Failure (HF) and Pneumonia (PN) 30 Day Readmission

Inclusions: Patients discharged with a primary diagnosis of AMI, heart failure or pneumonia who are readmitted for any diagnosis within 30 days of discharge (to any hospital).

Exclusions: Elective procedures. Observation status readmissions.

Goals: Rolling 3-month average for Aug-Sept-Oct: AMI: 10.6% Heart Failure: 17% Pneumonia: 14%

Data Source: Ace Web Reports, Qlikview Dashboard

Summary: While the 2010 readmission rate goals were achieved only for Pneumonia, the HF readmission rate did improve slightly at year-end. The AMI readmission goal was not met, but included only four patients in the denominator. Interventions initiated to support

Pneumonia 30 Day Readmission Rate
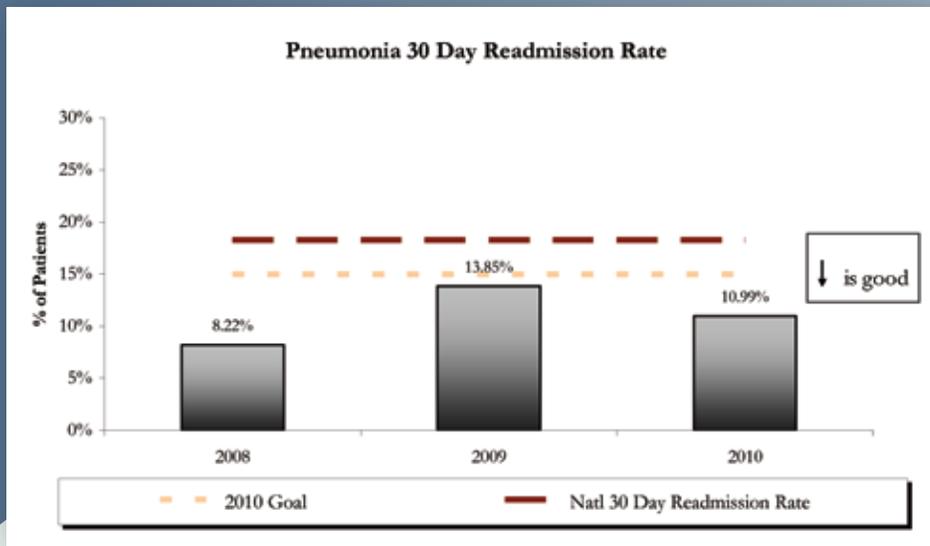
readmission reduction in 2010 included:
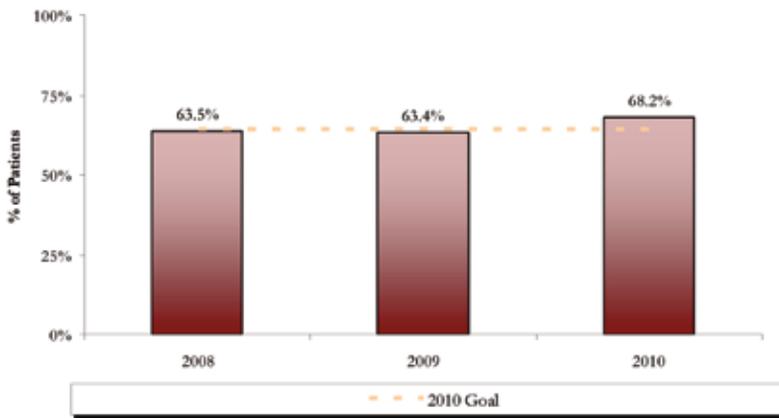- Concurrent monitoring process developed to identify readmissions while in hospital.
- Care Management developed need assessment questionnaire for HF patients used during initial admission.
- Care Management referrals to cardiac rehab for HF patients started. Cardiac rehab assesses HF patients for outpatient cardiac rehab referral.

Work will continue in 2011 to optimize Excellian order sets and documentation templates, enhance ongoing education documentation throughout the patient's stay, increase palliative care consults for HF patients, assure a low sodium (2 Gm) diet for all HF patients, hard wire teach back education by all disciplines and continue interdisciplinary heart failure education.
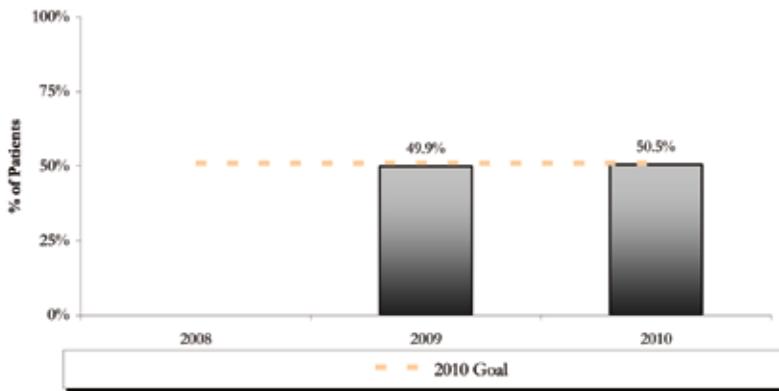
Leads: Val Enter, Gretchen Frederick and Readmission Steering Team

Overall Patient Satisfaction

Inpatient Overall Patient Satisfaction

- 2008: 63.5%
- 2009: 63.4%
- 2010: 68.2%
- - - - 2010 Goal

Outpatient Overall Patient Satisfaction

- 2009: 49.9%
- 2010: 50.5%
- - - - 2010 Goal

Measure: Inpatient and Outpatient Patient Satisfaction

Inclusions: Returned Adult HCAHPS Surveys (MedSurg, Specialty Care Unit, Birth Center) and Outpatient Allina Surveys (Emergency Department, Same Day Surgery, and Diagnostics).

Exclusions: Outpatient services other than those identified as inclusions, inpatient pediatric unit.

Goal: Inpatient: 64%
Outpatient: 51%

Data Source: Avatar web site HCAHPS survey; Allina patient satisfaction survey database, Qlikview Dashboard

Summary: Satisfaction goals were met and far exceeded in 2010. Site-based teams were developed for Patient Experience and Pain Management, with additional participation in Allina-wide committees for each of these as well. Additional initiatives in 2010 included:
- Leadership newspaper rounds on patients.
- New care boards in all IP rooms.
- Staff hourly rounding on patients.
- Implementation of room service in Birth Center.
- Warm & welcoming training.
- Facility updates – creation of a healing environment.
- Strong service recovery program.

Leads: Katie Roers, Gretchen Frederick

Communication with Doctors
Patient Satisfaction

MD Communication Patient Satisfaction
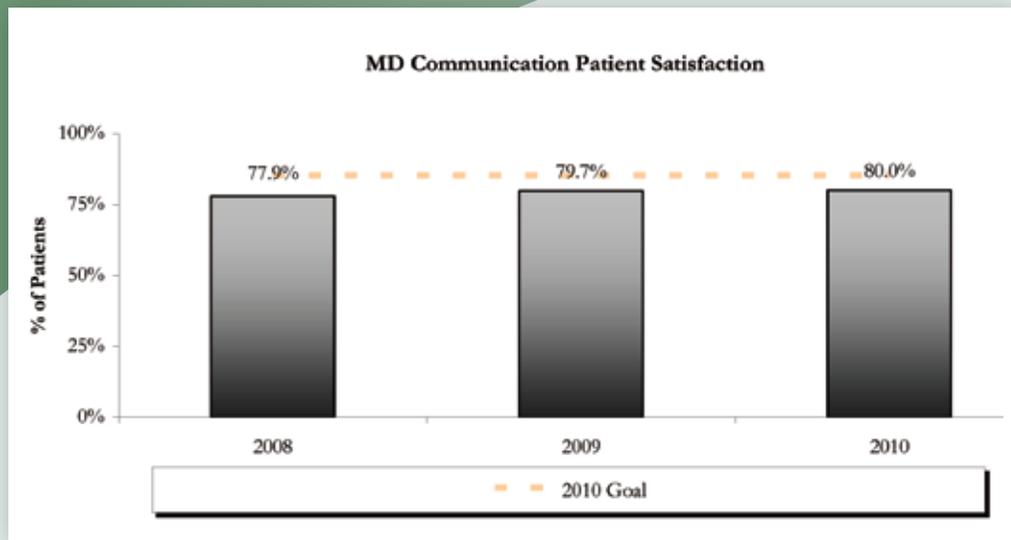
Measure: Communication with Doctors Satisfaction

Inclusions: Returned adult (Med Surg, Special Care Unit, Birth Center) HCAHPS surveys.

Exclusions: Outpatient services other than those identified as inclusions, inpatient pediatric unit.

Goals: 85.2% rolling three month average for Aug-Sept-Oct

Data Source: Avatar web site HCAHPS survey

Summary: The communication with doctors survey questions were selected as an Allina focus area in 2010 to assist in increasing overall inpatient satisfaction scores. Work at Buffalo Hospital has focused on:
• Developing hospitalist business cards with photos.
• Nurse-Physician Rounding.

• A plan for ongoing physician education was developed which included distribution of the system communication with doctors newsletter, inclusion of patient satisfaction information in medical staff monthly meetings and launching the Hospital Outstanding Patient Experience (HOPE) award recognizing exceptional physicians as recognized by patients.
• Additional tactics included use of the Care Board to identify the physician by name.

While the annual goal was not achieved, significant work was accomplished as the foundation for improvement in 2011.

Leads: Katie Roers/Gretchen Frederick/Corey Martin, M.D.

Pain Management Patient Satisfaction

Pain Management Patient Satisfaction

- 2008: 67.7%
- 2009: 69.5%
- 2010: 70.5%

- - 2010 Goal
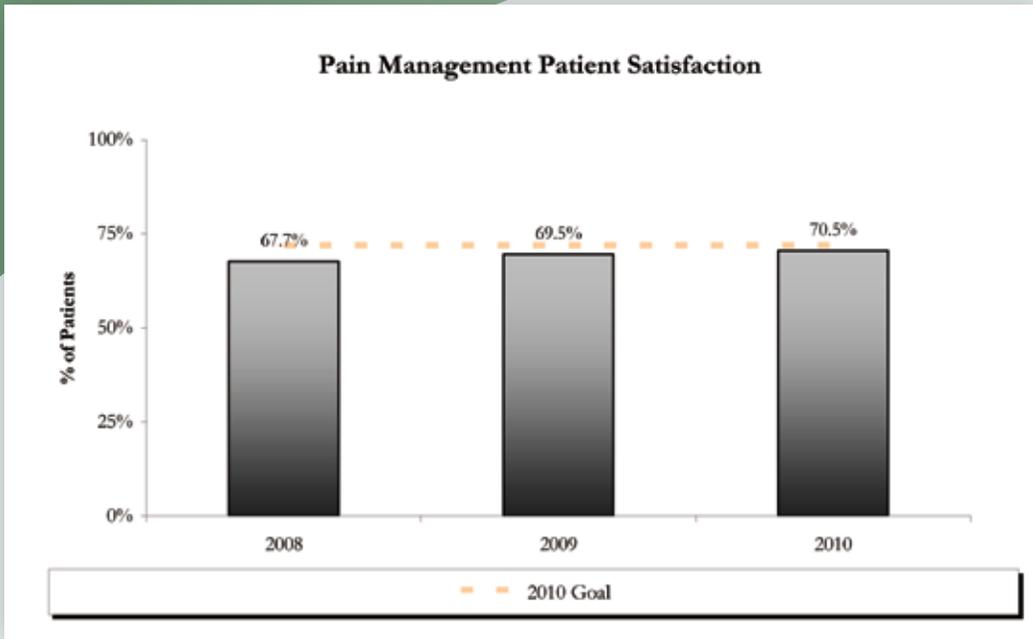
Measure: Pain Management Satisfaction

Inclusions: Returned adult (Med Surg, Special Care Unit, Birth Center) HCAHPS surveys.

Exclusions: Outpatient services other than those identified as inclusions, inpatient pediatric unit.

Goal: 71.9% rolling three month average for Aug-Sept-Oct

Data Source: Avatar web site HCAHPS survey

Summary: This was the first year of a dedicated system-wide pain experience initiative. A multidisciplinary team was created at Buffalo to address patient pain experience goals. There were multiple system tactics which the site team participated in:
- Nursing education (general and OB specific).
- Excellian enhancements, including redesign of pain order sets.
- Site-lead pain conference (Perspective on Pain).
- Revision of the patient pain brochure.
- Standardized Allina Care Boards were placed on Med-Surg, SCU and in the Birth Center.

Leads: Katie Roers/Cindy Oquist and the Pain Experience Team

Safety Culture Survey

SURVEY RESULTS NOVEMBER 2010	Buffalo Hospital	Allina Health System	50-99 bed Benchmark Hospitals
PARTICIPANTS:	244	4,999	338,607
Overall perceptions of safety	71%	54%	68%
Frequency of events reported	68%	52%	64%
Supervisor/manager expectations & actions promoting safety	85%	67%	77%
Organizational learning – Continuous improvement	79%	64%	73%
Teamwork within units	88%	77%	80%
Communication openness	73%	58%	63%
Feedback & communication about error	69%	52%	65%
Nonpunitive response to error	60%	43%	46%
Staffing	65%	51%	58%
Hospital management support for patient safety	80%	60%	74%
Teamwork across hospital units	67%	53%	60%
Hospital handoffs & transitions	51%	41%	48%

Measure: Staff perception of patient safety culture

Hospital Goals for 2011:
- Increase reporting of near misses and patient events.
- Develop improved communication plan for sharing PVSR data and resulting actions.

Data Source: AHRQ Survey on Patient Safety Culture

Summary: In 2011, Allina chose to use the AHRQ survey to evaluate our patient safety culture. The overall survey results for Buffalo Hospital were the second highest in Allina and above all National Benchmarks for hospitals of similar size. Results were reviewed by each department leader with staff and action plans developed for departments whose scores were below benchmarks. This survey will be repeated on an annual basis and scores trended from year to year.

Leads: Val Enter, Manager of Quality, Risk & Patient Safety

Patient Visitor Safety Event/Near Miss Reporting (PVSR)

Total Patient Visitor Safety Reports

Near Miss Patient Visitor Safety Reports

Coded Patient Visitor Safety Reports
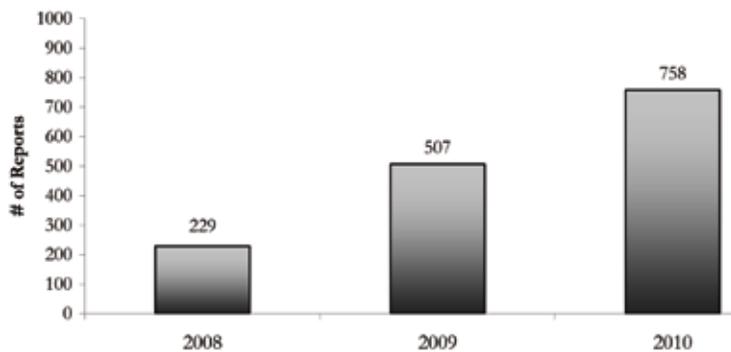
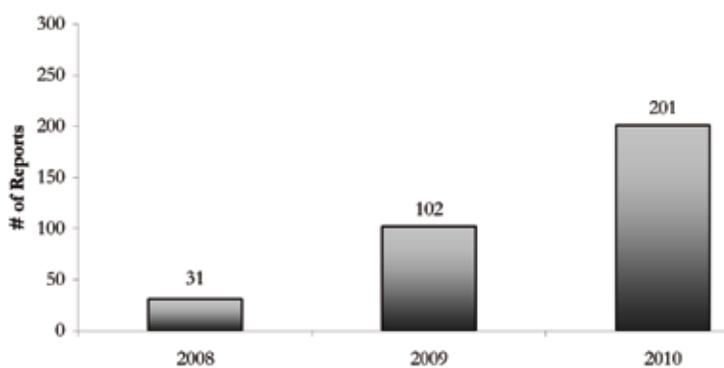**Measure:** Patient Visitor Safety Event/Near Miss Reporting

Inclusions: All inpatients, outpatients and visitors.

Exclusions: Employee or campus partner clinic patient events.

Goals: 10% increase in reporting from 2009 rate

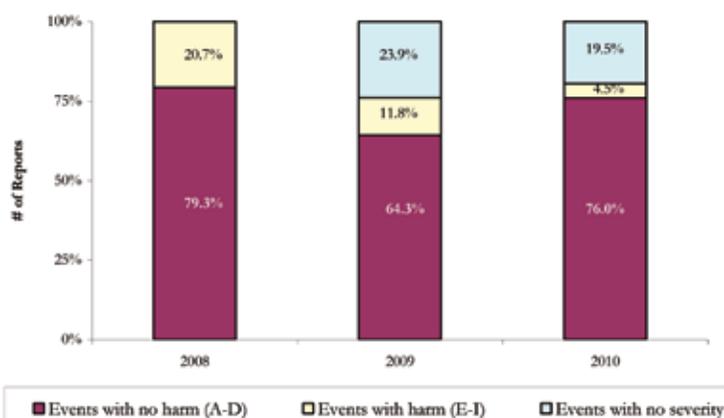**Data Source:** Patient Visitor Safety Report (PVSR) Database

Summary: The majority of the events with harm fall into the temporary/minor harm category. Strategies used to increase PVSR reporting included communications in Patient Care Notes Newsletter, leadership support via patient safety messages in the president Friday newsletter and manager weekly emails, and completion of the patient safety culture survey information sharing with staff.

Reporting for all events and good catch/near miss events increased significantly in 2010 with goal achievement attained. The majority of these events are coded as no harm with a consistent 4% harm rate for the past three years. Events with no severity assigned are laboratory reported events which have a coding process specific to the department. The Laboratory Department is a strong patient safety advocate with event reporting surpassing all other departments.
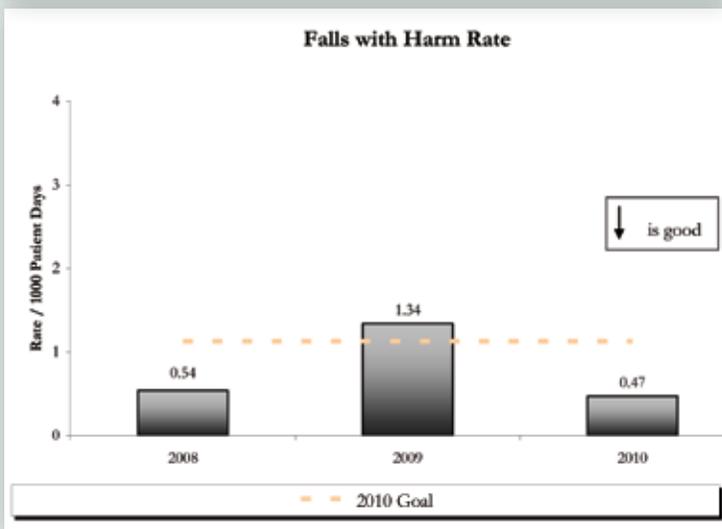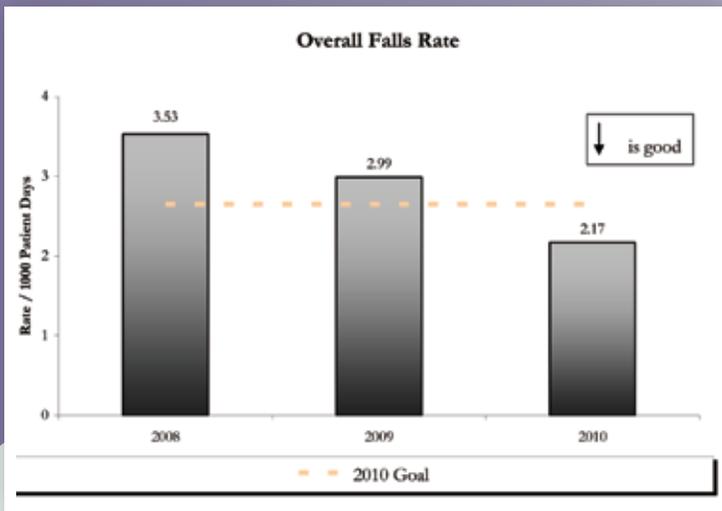
Hospital Goals for 2011:
- 8% increase in Near Miss Reporting from 2010 rate.
- Continue to increase reporting of patient events.
- Implementation of leader rounding on staff with patient safety questions.

Leads: Val Enter, Manager of Quality, Risk & Patient Safety

Falls

Overall Falls Rate

Falls with Harm Rate

Measure: Inpatient Falls/Falls with Harm

Inclusions: Inpatient Falls

Exclusions: Outpatient falls

Goal: Overall Falls Rate < 2.65 falls per 1000 patient days; Harmful Falls Rate < 1.13 falls per 1000 patient days.

Data Source: Patient days from financial data; fall data from Clarity and PVSR database

Summary: The 2010 goal was achieved with a rate of 0.47 harmful falls per 1000 patient days or 3 inpatient falls with harm. The 2010 goal for overall rate of falls was also achieved with a rate of 2.17 falls per 1000 patient days or 14 falls. Interventions which assisted in goal achievement include:

- Real time audits done to measure required fall interventions.
- Increased the representation from outpatient departments on falls team.
- Developed guidelines to match interventions with Hendrich II assessment items.
- Met with ancillary departments to share fall reduction strategies, creating a safety net of healthcare workers to assist in fall reduction.
- Emphasis on toileting with patient rounding.
- Implemented post-fall huddle process.
- Reinforced staff education on use of the fall risk tool, specifically the get-up-and-go measurement.
- Staff shared "real life" accounts of experiences with patient falls and learnings from falls. These accounts were communicated to staff in nursing newsletter and staff meetings.

Work will continue in 2011 in alignment with Allina system-wide strategies including a focus on: equipment needs, vitamin D use, scheduled toileting and Within Arms Reach initiatives, consistent messaging on Care Boards, development of a fall prevention toolkit, fall education to all staff, role modeling of verbal contracts and pharmacy review for medication impact.

Leads: Katie Roers/Raelene Fairchild and the Fall Prevention Team

Adverse Health Events/Critical Event Reviews

During 2010, six Critical Event Reviews (CER) were conducted (3-newborn events, violent patient incident, fall with injury, and an ED multiple trauma incident). These events included one reportable Adverse Health Event (AHE), a fall with injury requiring return to surgery. AHEs are those events deemed reportable by MN statute 144.4065. Adequacy of staffing was assessed for all CERs. No staffing concerns were identified. Learnings from CER's were shared with staff as appropriate to prevent future occurrences.

In 2010, Buffalo Hospital participated in the Minnesota Hospital Association "Calls to Action" for Safe Skin, Safe from Falls, Safe Site, Safe Count, and Safe Account. Buffalo has completed the improvement road map for four of the calls to action, receiving a patient safety excellence award for these initiatives. Work continues on the Safe Account initiative with plans to complete in 2011.

Failure Mode Effect Analysis

Two Failure Mode Effect Analysis (FMEA) were conducted on the universal protocol, one in surgical services and one in the diagnostic imaging department. Action plans were shared with the Allina system as a precursor to redesign of the universal protocol checklist/transition to the World Health Organization (WHO) checklist.

Lead: Val Enter, Manager of Quality, Safety & Risk Management.

Regulatory & Accreditation Readiness

Number of Joint Commission Standards	Number of Standards in Full Compliance in 2010	Summary
281	278	3 at less than 66% compliance – Hand hygiene under Infection Control and the National Patient Safety Goal – Patient identification (patient banding in the ED and patient being entered into the EMR in the ED under wrong name)

Measure: Compliance with regulatory and accreditation standards

Inclusions: Standards for which non-compliance or partial compliance is determined and plans of action developed

Exclusions: Standards considered compliant or easily brought into compliance

Goals:
- Successful Allina Internal Regulatory Survey.
- Annual completion of the Joint Commission Periodic Performance Review.

Data Source:
- Survey results from Allina Internal Regulatory Survey.
- Chapter lead identification of partially compliant/non-compliant standards.

Buffalo Hospital actively maintains compliance to The Joint Commission (TJC) and CMS (Centers for Medicare and Medicaid Services) requirements within the framework of Allina's Regulatory Reliability model which supports ongoing regulatory compliance and survey readiness. Leads are identified for each of the Joint Commission chapters and work collaboratively with the Regulatory Lead to provide oversight and successful preparation and submission of the 2010 Periodic Performance Review (PPR). This includes the development of corrective action plans to address reported areas of non-compliance. The corrective action plans were submitted and accepted by The Joint Commission during the PPR follow-up phone call. Buffalo Hospital successfully transitioned to the Allina

Regulatory Accreditation System (ARAS) tool. This tool is an electronic program that assists in managing ongoing compliance to TJC standards. The tool is designed to score compliance and document supporting evidence for each of TJC standards and includes the ability to enter corrective action findings and plans when standards are identified as non-compliant. The ARAS tool is currently utilized by the Regulatory Lead for documentation compliance input from Chapter Leads and for the annual PPR preparation.

In March of 2010, Buffalo Hospital had a successful two day Allina internal regulatory accreditation survey which was coordinated and conducted by the Allina regulatory leads from across the system. The surveys are designed to replicate an actual Joint Commission survey by incorporating the same patient tracer methodology utilized by TJC. Non-compliant internal findings were evaluated by responsible individuals and corrective actions were put in place to bring the requirements into compliance. The internal survey findings were entered into the ARAS tool and became helpful adjuncts during the preparation of the 2010 PPR.

Additional regulatory readiness activities in 2010 included the development of numerous educational materials, such as the monthly Joint Commission calendars, 2011 NPSG poster, information submitted to Buffalo Hospital publications such as Patient Care Notes and This Week at Buffalo. These educational materials are used to help prepare all employees and physicians for a successful survey which will occur before the end of 2011.

Lead: Pat Marschel, Quality Improvement Specialist/Regulatory Lead

Performance Improvement

Med-Surg/SCU

- Initiated physician/nurse rounding process.
- Standardizing nurse-to-nurse handoffs with PACU and Imaging.
- Improved ED admit process.
- Behavioral Health education and pathway use.
- Trauma education for SCU nurses.
- Strengthening our Nursing Governance Model.
- Initiated processes to help improve the care experience for surgical ortho and peds patients.
- Safe Patient Moving fair held in October to educate staff on moving patients safely – for the patient and the staff person.

Emergency Department

- Developed a quality scorecard for ED.
- Installed patient satisfaction vendor software to assist in analyzing ED satisfaction at discharge and identify areas of improvement. Results shared with providers and staff regularly.
- Registration and ED staff worked collaboratively to improve patient banding processes.
- Suicide Risk Screening increased from 50% to 97% compliance.
- Weekend staffing hours were increased and shifts times altered to better cover times of high census.
- New model of care called "pull til you're full" trialed in November, and proved to decrease benchmark times from the current average of 34 minutes to 27 minutes. This model will be fully implemented in January of 2011.
- Implemented 24/7 emergency department technician coverage in March of 2010. Since this implementation, lab turnaround times and EKG turnaround times have decreased.
- Emergency department is now a locked unit.
- Panic button installed in the department. When pushed, this alerts local authorities and assistance is immediately sent to the ED.
- Addition of seven cardiac monitors so that all emergency department and urgent care rooms are equipped to monitor and treat acutely ill patients.
- A new protocol for assessment and treatment of behavioral health patients was developed and implemented in 2010.
- Moved the charge nurse meetings from every other month to monthly with focus for 2011 on the development of professional nursing and enhancing effective communication within the department.

Same Day Surgery/PACU

- Multidisciplinary group developed to work on implementing MAPS Safe Scheduling practices.
- Multidisciplinary group developed to work on improving scheduling processes for procedure patients.
- Evaluated overall staffing patterns as compared to volumes.
- Staff attended Safe Patient Moving fair held in October.
- Evidence based standards developed to promote consistency and excellence in nursing practices.
- Preadmission processes redesigned to improve safety and efficiency.
- Standard competencies/accountabilities developed for staff.
- Purchased wireless phones for improved staff communication across surgical services.
- Discharge Writer streamlined for both staff and patient satisfaction.

Safety/Security

- Security-office moved to new location closer to ED.
- Increased security coverage to 24/7 service.
- Security involvement/co-lead with Disaster Committee.
- Construction safety – daily and weekly meetings conducted with contractors when construction in process.

Registration

- Warm and Welcoming training for all Registration staff.
- Urgent Care Bed Side Registration.
- Developed patient routing slip for clinics to use when sending patients for hospital services.
- Using Status Blue system to sign in all surgery vendors.
- Implementation of pre-registration for scheduled outpatient Birth Center services.
- Implementation of nightly review of Important Message from Medicare for Inpatients.
- Implementation of daily review for Auth/Consent forms to ensure valid auth is on file and scanned into Excellian.
- Additional Medicare Secondary Payor Questionnaire training.
- Installed locked drawer in Main Registration to secure patients payments.

Care Management

- New template for Care Management Assessment to standardize department documentation.
- Standardized documentation for Advance Care Planning.
- MARTII is available for interpreter services to meet the needs of the patients and staff.
- CHF template and tools to work with these points and readmissions.
- Policy of the month during Care Management department meetings – review and discussion on policies that may pertain to our department.
- Collaboration with AMC OB Educator for high risk pregnant women for resources and needs.
- DRG/UR work on the weekends to monitor compliance with orders and event management.
- Morning "huddle" and end of day "huddle" for handoff communication on patient involvement.
- Daily assignment sheet for M/S and ED on staff following pt's, as well as document in Staff Alerts.
- Attendance at hospital departments for education on abuse reporting and interpreter services.

Physical Therapy

- Added Lymphedema Therapy Services and Driving Assessments to meet the needs of our community.
- Improving preoperative work flow and care experience for total joint patients to achieve excellent outcomes and improve patient satisfaction/experience.
- Physical Therapists involved in Skin Integrity team, safe patient handling/falls committee, Patient Satisfaction team, and participate in daily Care Management meetings.
- Monthly professional practice meetings to share learnings and update best of practice information.
- Safe Patient Moving fair held in October to educate staff on moving patients safely – for the patient and the staff person.

Oncology

- Cross-trained additional staff for Oncology Services.
- Oncology Coordinator served on the Oncology User Group team which looks at oncology practice and order sets across Allina to ensure best of practice.

Birth Center

- Goal in 2010 – No elective inductions <39 weeks without medical indication or proven amnio; baseline induction rate of elective inductions <39 weeks was at 9.9% YTD (Oct 2010) dropped to 4.4%.
- Strong focus on Provider Rounding with nursing 100% of the time.
- 5 Nurses have achieved their RNC in Newborn care and OB care.
- 2 - IBCLC in the Birth Center to assist our patients with Lactation services.
- Implementation of induction of labor guidelines and the new Oxytocin order set have established the gold standard of care for the management of patients.
- Scheduling all procedures in Cadence in Excellian.
- Monthly mock C/S and neonatal codes starting in March.
- Focused on creating a healing and calming environment for patients: DVD and IPod® docking stations in all patient care rooms. Care channel is on when the patient is admitted to the room. Rubber flooring creates a quieter environment when rolling carts and beds.
- Strong focus on setting realistic expectations with the pain goal.
- Implemented room service in August 2010 to improve customer service in the area of meal service.

Lab

- Conducted two outpatient satisfaction surveys and one nursing satisfaction survey (system-wide surveys).
- Maintained accreditation with AABB for transfusion services – this is an optional accreditation and Buffalo Hospital is the only regional hospital with this accreditation.
- Working on implementing a different whole blood analyzer for some of the chemistry testing.
- Working with ED on tracking hemolysis rates.
- Continue to work with AML on standardization of processes and procedures.
- Specimen labeling improvement with Surgery.

Respiratory Therapy

- All cases involving patients being transferred from ED to other hospitals that require CPAP or bi-level are

reviewed to ensure the appropriate support is given patients.

- Support use of Rapid Response team by timely and appropriate interventions.
- Clinical Emergency Response Team working to identify patient populations that are at risk for post-op use of narcotics.
- Developing process for screening patients with Sleep Apnea pre-operatively.

Cardiac Services

- Developed and implemented outpatient cardiac rehab program to assist patients with Heart Failure.

Medical Staff

- Physician satisfaction survey.
- 24/7 Hospitalist schedule is being reviewed and they are working on the new contract.
- Geriatric Services Group has contracted with Buffalo Clinic and AMC to do all nursing home coverage.
- Video for physician orientation that will come from Allina.

Medical Staff Office

- Credentialing database consolidated from three separate to one shared Allina database.
- Bylaws updated with a statement to share credentialing information across facilities.
- Ongoing Professional Practice Evaluations done every 6 months and filed in provider's quality file.
- Transition to a paperless credentialing file initiated.
- Work initiated to update privilege forms to reflect current scope and practice.

Materials Management

- Most supplies moved into bar coded bins for easier access and ability to inventory the supplies.
- Daily cycle counting in the storeroom to assure accurate supply counts.
- Took over Respiratory supply ordering to assure supply availability to meet the needs of our patients and staff.

Nutritional Services

- Transitioned to passing patient food trays to M/S patients – improved nursing satisfaction, and improved nutritional services connection to patients.
- Eliminated salad bar by providing pre-made salads – more cost effective and safer food handling.
- Staff education regarding Gluten-free diet to ensure appropriate diet to patients.

Finance

- Additional training for Analyst use of report writer and of the warehouse data.
- Contract process refined to increase compliance with regulatory requirements.
- Additional training for Cashier/Specialist to use the new productivity system and the new budgeting system.

Environmental Services

- Implementation of infection control surveys.
- Annual scorecard developed with goals for excellent patient care.

Center for Learning & Development

- Simulation lab here for one day to provide rapid response team education.
- Managing transitions with the systemization of Education Services.
- Incorporated core measures, patient safety, etc. into education classes.
- Contributed to quality of care through clinical simulation exercises.

Medical Nutrition Therapy

- Reporting quality info to M/S Manager to help improve consistency of nutritional assessment on admission.
- Continuing to expand self-referral program.

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