

Delivering the Right Care

	National	Iowa	Jennie
Heart Attack			
Aspirin at Arrival Aspirin can help keep blood clots from forming and dissolve blood clots that can cause heart attacks.	95	95	99
Aspirin at Discharge Taking aspirin may help prevent further heart attacks.	94	92	97
ACE – I/ARB at Discharge ACE (angiotensin converting enzyme) inhibitors and ARBs (angiotensin receptor blockers) are medicines used to treat heart attacks, heart failure, or a decreased function of the heart.	93	93	100
Smoking Counseling Smoking is linked to heart attacks. Quitting may help prevent another heart attack.	97	98	100
Beta Blocker at Discharge Beta blockers are a type of medicine used to lower blood pressure, treat chest pain (angina) and heart failure, and to help prevent a heart attack.	94	94	97
Fibrinolytic Medication within 30 Minutes of Arrival Blood clots can cause heart attacks. Doctors may give this medicine, or perform a procedure to open the blockage, and in some cases, may do both.	46	75	0*
Time to Primary PCI of Less than or Equal to 90 Minutes The procedures called Percutaneous Coronary Interventions (PCI) are among those that are the most effective for opening blocked blood vessels that cause heart attacks. Doctors may perform PCI, or give medicine to open the blockage, and in some cases, may do both.	84	88	77
Heart Failure			
Discharge Instructions The staff at the hospital should provide you with information to help you manage your heart failure symptoms when you are discharged.	80	75	100
LVS Assessment An evaluation of the LVS function checks how the left chamber of the heart is pumping.	91	84	98
ACE – I/ARB at Discharge ACE (angiotensin converting enzyme) inhibitors and ARBs (angiotensin receptor blockers) are medicines used to treat heart attacks, heart failure, or a decreased function of the heart.	90	86	95
Smoking Counseling Smoking is linked to heart failure. Quitting may help improve your condition.	93	79	100

*This hospital has treated patients in this condition, but no patients met the criteria for inclusion in the measure calculation.

Data Last Updated: October 7, 2010
Source: www.hospitalcompare.hhs.gov

Delivering the Right Care

	National	Iowa	Jennie
Pneumonia			
Pneumovax Vaccination A pneumonia (pneumococcal) shot can help prevent pneumonia in the future, even for patients who have been hospitalized for pneumonia.	88	89	92
Timing of Blood Cultures - Emergency Dept A blood culture tells what kind of medicine will work best to treat your pneumonia.	93	94	94
Smoking Counseling Smoking is linked to pneumonia. Quitting may help prevent you from getting pneumonia again.	91	82	98
Antibiotics within 6 hours Timely use of antibiotics can improve the treatment of pneumonia caused by bacteria.	94	95	98
Selection of Antibiotics Antibiotics are medicines that treat infection, and each one is different. Hospitals should choose the antibiotics that best treat the infection type for each pneumonia patient.	89	90	84
Patients Assessed and Given Influenza Vaccination An influenza shot can help prevent influenza in the future, even for patients who have been hospitalized for pneumonia.	86	86	67
Surgery			
Treatment to prevent blood clots ordered after surgery This measure tells how often surgery patients' doctors ordered treatment to prevent blood clots from forming in the veins after certain surgeries	89	87	82
Blood Clot Treatment received within 24 hours before/after surgery This measure tells how often surgery patients received treatment to prevent blood clots within 24 hours before or after certain surgeries	88	84	82

Data Last Updated: October 7, 2010
Source: www.hospitalcompare.hhs.gov

Surgical Care Improvement Project

	National	Iowa	Jennie
Antibiotics Given at the Right Time This measure tells how often patients having certain types of surgery received treatment to prevent blood clots in the period from 24 hours before surgery to 24 hours after surgery.	93	95	96
The Right Kind of Antibiotic Given to Prevent Infection Some antibiotics work better than others to prevent wound infections for certain types of surgery. This measure shows how often hospital staff make sure patients get the right kind of preventive antibiotic medication for their surgery.	95	93	95
Antibiotics Stopped at the Right Time Taking preventive antibiotics for more than 24 hours after routine surgery is usually not necessary. This measure shows how often hospitals stopped giving antibiotics to surgery patients when they were no longer needed to prevent surgical infection.	91	93	92
Blood Sugar Kept Under Control Right After Surgery All heart surgery patients get their blood sugar checked after surgery. Any patient who has high blood sugar after heart surgery has a greater chance of getting an infection. This measure tells how often the blood sugar of heart surgery patients was kept under good control in the days right after their surgery.	91	89	0
Hair Removal Needed For those patients who needed to have hair removed to prepare for surgery, this measure tells how often one of the safer methods was used (electric clippers or hair removal cream).	98	99	99
Doctors Ordered Treatments to Prevent Blood Clots Certain types of surgery can increase patients' risk of having blood clots after surgery. For these types of surgery, this measure tells how often treatment to help prevent blood clots was ordered by the doctor.	89	87	82
Treatment Received at the Right Time This measure tells how often patients having certain types of surgery received treatment to prevent blood clots in the period from 24 hours before surgery to 24 hours after surgery.	88	84	82

Data Last Updated: October 7, 2010

Keeping Patients Safe

	National	Iowa	Jennie
Healthcare Associated Infections			
MRSA Incidence	ND	ND	ND
VRE Incidence	ND	ND	ND
Hand Hygiene	ND	ND	ND
Nursing Sensitive			
Patient Falls with Injury on Medical Units	ND	ND	ND
Patient Falls with Injury on Surgical Units	ND	ND	ND
Pressure Ulcer – Incidence on Medical Units	ND	ND	ND
Pressure Ulcer – Incidence on Surgical Units	ND	ND	ND

ND = No Data

Listening to Patients

	National	Iowa	Jennie
Patient Experience – Adult Inpatient			
Overall	66%	72%	67%
Recommendation	69%	72%	72%
Communications with Nurses	75%	79%	79%
Communications with Doctors	80%	82%	83%
Communication about Medications	60%	63%	60%
Responsiveness of Hospital Staff	63%	67%	68%
Room Cleanliness	70%	76%	67%
Quiet at Night	57%	61%	54%
Pain Management	69%	70%	70%
Discharge Information	81%	84%	85%

Keeping Patients Safe - 2007 Safety Goals

Improve the accuracy of patient identification.	
Use at least two patient identifiers when providing care, treatment or services.	IMPLEMENTED
Improve the effectiveness of communication among caregivers.	
For verbal or telephone orders or for telephonic reporting of critical test results, verify the complete order or test result by having the person receiving the information record and “read-back” the complete order or test result.	IMPLEMENTED
Standardize a list of abbreviations, acronyms, symbols, and dose designations that are not to be used throughout the organization.	IMPLEMENTED
Measure, assess, and if appropriate, take action to improve the timeliness of reporting, and the timeliness of receipt by the responsible licensed caregiver, of critical test results and values.	IMPLEMENTED
Implement a standardized approach to “hand off” communications, including an opportunity to ask and respond to questions.	IMPLEMENTED
Improve the safety of using medications.	
Standardize and limit the number of drug concentrations used by the organization.	IMPLEMENTED
Identify and, at a minimum, annually review a list of look-alike/sound-alike drugs used by the organization, and take action to prevent errors involving the interchange of these drugs.	IMPLEMENTED
Label all medications, medication containers (for example, syringes, medicine cups, basins), or other solutions on and off the sterile field.	IMPLEMENTED
Reduce the risk of health care-associated infections.	
Comply with current Centers for Disease Control and Prevention (CDC) hand hygiene guidelines.	IMPLEMENTED
Manage as sentinel events all identified cases of unanticipated death or major permanent loss of function associated with a health care-associated infection.	IMPLEMENTED
Accurately and completely reconcile medications across the continuum of care.	
There is a process for comparing the patient’s current medications with those ordered for the patient while under the care of the organization.	IMPLEMENTED
A complete list of the patient’s medications is communicated to the next provider of service when a patient is referred or transferred to another setting, service, practitioner or level of care within or outside the organization. The complete list of medications is also provided to the patient on discharge from the organization.	IMPLEMENTED
Reduce the risk of patient harm resulting from falls.	
Implement a fall reduction program including an evaluation of the effectiveness of the program.	IMPLEMENTED
Encourage patients’ active involvement in their own care as a patient safety strategy.	
Define and communicate the means for patients and their families to report concerns about safety and encourage them to do so.	IMPLEMENTED
The organization identifies safety risks inherent in its patient population.	
The organization identifies patients at risk for suicide. Note: This requirement only applies to psychiatric hospitals and patients being treated for emotional or behavioral disorders in general hospitals.	IMPLEMENTED
Universal Protocol	
Conduct a pre-operative verification process.	IMPLEMENTED
Mark the operative site.	IMPLEMENTED
Conduct a “time out” immediately before starting the procedure.	IMPLEMENTED

Nine Patient Safety Solutions

1. Look-Alike, Sound-Alike Medication Names

Confusing drug names is one of the most common causes of medication errors and is a worldwide concern. With tens of thousands of drugs currently on the market, the potential for error created by confusing brand or generic drug names and packaging is significant.

2. Patient Identification

The widespread and continuing failures to correctly identify patients often leads to medication, transfusion and testing errors; wrong person procedures; and the discharge of infants to the wrong families.

3. Communication During Patient Hand-Overs

Gaps in hand-over (or hand-off) communication between patient care units, and between and among care teams, can cause serious breakdowns in the continuity of care, inappropriate treatment, and potential harm for the patient.

4. Performance of Correct Procedure at Correct Body Site

Considered totally preventable, cases of wrong procedure or wrong site surgery are largely the result of miscommunication and unavailable, or incorrect, information. A major contributing factor to these types of errors is the lack of a standardized preoperative process.

5. Control of Concentrated Electrolyte Solutions

While all drugs, biologics, vaccines and contrast media have a defined risk profile, concentrated electrolyte solutions that are used for injection are especially dangerous.

6. Assuring Medication Accuracy at Transitions in Care

Medication errors occur most commonly at transitions. Medication reconciliation is a process designed to prevent medication errors at patient transition points.

7. Avoiding Catheter and Tubing Mis-Connections

The design of tubing, catheters, and syringes currently in use is such that it is possible to inadvertently cause patient harm through connecting the wrong syringes and tubing and then delivering medication or fluids through an unintended wrong route.

8. Single Use of Injection Devices

One of the biggest global concerns is the spread of Human Immunodeficiency Virus (HIV), the Hepatitis B Virus (HBV), and the Hepatitis C Virus (HCV) because of the reuse of injection needles.

9. Improved Hand Hygiene to Prevent Health Care-Associated Infection (HAI)

It is estimated that at any point in time more than 1.4 million people worldwide are suffering from infections acquired in hospitals. Effective hand hygiene is the primary preventive measure for avoiding this problem.