**HQSC 10.19.22 Meeting Minutes**

In attendance: Haley Manella, Ethan Witt, Kit Lum, Andrew Gledhill, David Mazur-Hart, Kristen Kraimer, Leah Calvert, Mara Peterson, Michelle Lawson, Nasser Yaghi, Ryan Kane, Sydney Landreth, Eric Nomura, Sam Milholland, Chenara Johnson

* **Deterioration Index Compass Module – Kit Lum**
  + Following IHI’s update regarding rapid response. Potentially being altered earlier in changes that could lead to adverse events. Looked at various early warning scoring systems and did evidence-based practice and ran info against patients who have had Code Blues. EPIC was developing their own system at this time. Ran deterioration index and found that it was easy to use and the most accurate in determining subtle changes in patients that might need a closer look. The function is available in EPIC but it wasn’t really advertised. A PA found it and started using it not knowing what it did. Noticed a patient went to acute care and had a huge shift in deterioration index. The patient was sent back to OR to fix bleeding. Vital signs, assessment data, and lab values showed change over time. This index will help us respond to a “spark” before it becomes a “fire.” The time from identification and intervention can sometimes take a while and sometimes it can be too late. Implementing this may lead to decreased admission to ICU or getting patients to the ICU before something worse happens (Code Blue).
  + Color coded (green, yellow, red) and updated every 20 mins. Rapid response team is paged for patients that have a score of 70 or higher. Moving to the next phase and trying to get all clinicians to monitor the SI score.
  + Anyone can use the DI (see slide)
  + Patient had a DI score that went from 48 to 75 and team was automatically paged. Primary team was involved and patient was taken to CT scan and diagnosed with acute pancreatitis and transferred to MICU and intubated. One example in how this notifies us of subtle changes.
  + Look at the DI score and correlate it with clinical assessments. See how changes in the score look in your patients. There is an 8 minute course in Compass to help learn how to use it. Periodically check your patients DI score and make informed decisions as a tool in your clinical toolbelt.
  + *Ethan Witt*: Has this had an impact on workflow on RRT teams?
  + *Kit Lum*: Yes, it made them busier and added a few more activations. We have the ability to evaluate and time it so it can be turned off. If we receive a DI score for certain patients (comfort care, etc.) then those can be turned off. Some patients with TBIs that are not going to improve will have stable scores and the RNs are not concerned so the alerts will be turned off.
  + *Ryan Kane*: Are you doing an outcome study based on this? Does it increase number of RRTs?
  + *Kit Lum*: If we are intervening early then we can stabilize and keep in acute care. Looking at the number of acute care code activations. We would like to see code blue activations in acute care go down.
  + *Eric Nomura*: Do you have data on false positive/negative rates for DI?
  + *Kit Lum*: It had better sensitivity than other early warning systems.
  + *Haley Manella*: Has anyone heard about this or used it yet? (Everyone: No)
  + Foresee a future where we talk about concern over DI score. Want to be able to refer to it and have everyone understand what it means.
* **Project Review – Ryan Kane**
  + Standardizing Interdepartmental Handoffs at OHSU
    - We have been collecting data since end of June. We have 40 responses. We put QR codes on flyers around hospital, sent emails, and talked about it at IM conferences. Thinking this is not a good way to collect data. We have done IM and EM specific trainings at providing interdepartmental handoffs. Any ideas on how we can collect more data? See if there’s improvement in giving handoffs from one academic year to the next. Since data collection has been minimal we likely would not be able to say anything meaningful about this.
    - *Eric Nomura:* Data collection through MedHub survey along with rotation evaluations
    - *Andrew Gledhill*: Can someone review admits for week and reach out to people involved and asking them to fill out the form?
    - *Ryan Kane*: We don’t have bandwidth for this but can look into it.
    - *Haley Manella*: We could actually observe the handoff.
    - *Ethan Witt*: Can we recruit med students to help with observation?
  + Language Services Project Update
    - Walking around with QR code and asking house staff to complete a survey in the moment. Asking how we can improve it**.**
* **PSI Review – Ethan Witt**
  + PSI SI-81508: (see slide)
  + PSI SI-81674: (see slide)
  + PSI SI-80797: Outside of the ICU, RNs do not do labs but phlebotomy will. If there are IV draws then the RNs will send labs. It could be improved by having reliable phlebotomy, it’s an important role. Would more RNs be willing to help out and be trained if they knew that this was an issue? Maybe we won’t escalate this issue but we can reach out to nursing and brainstorm how to fix this problem. Continue to track this and see how big of a problem it actually is. Mara Peterson will help with this PSI.
  + PSI SI-82834: This has been seen in several recent PSIs. One thing we need to think about is ownership of patients and taking a pause to verify if this is indeed your patient. Be aware of this issue. Has a conversation been had regarding ownerships of patients? Nurses are feeling abandoned.