(OAK BROOK, Illinois, October 27, 2015) – Joint Commission Resources, Inc. today released the November 2015 issue of The Joint Commission Journal on Quality and Patient Safety, featuring an article on how Houston Methodist Hospital (HMH), Houston, Texas, prioritized sepsis detection and management in its intensive care unit (ICU) to decrease inpatient death rates and costs.

The article, “Reductions in Sepsis Mortality and Costs After Design and Implementation of a Nurse-Based Early Recognition and Response Program,” by Stephen L. Jones, MD, MSHI, and colleagues, highlights the development of the HMH sepsis program, first implemented in 2009. Designed to be readily used by nurses, the sepsis program helped with the early recognition of patients showing signs of possible infection, as well as the institution of prompt, evidence-based interventions to diagnose and treat it.

The interventions consisted of four components: organizational commitment and data-based leadership; development and integration of an early sepsis screening tool into the electronic health record; creation of screening and response protocols; and education and training of nurses. In addition, twice-daily screenings of patients on targeted units were conducted by bedside nurses, and nurse practitioners initiated definitive treatment as indicated.

By the third year of the sepsis program (2011), 33 percent of inpatients were screened, up from 10 percent in the first year. Inpatient sepsis-associated death rates decreased from 29.7 percent in the pre-implementation period (2006–2008) to 21.1 percent.
percent after implementation (2009–2014). Death rates and hospital costs for Medicare beneficiaries also decreased from pre-implementation levels.

The authors state that their program’s unique factors are “its focus on all inpatients, not just patients in the ICU; the goal of identifying sepsis early, before it progresses to severe sepsis and septic shock; the fact that nurses are the frontline implementers of screening and response protocols; the intensive simulation training that second-responder nurses undergo; and the seamless integration of the screening tool into the hospital's electronic data and information systems supporting bedside patient care.”

The remaining articles from the November 2015 issue are:

**Risk Assessment and Event Analysis**

**Learning by “SWARMing” Adverse Events**

*Donald Kennerly, MD, PhD*

In this editorial, Dr. Kennerly suggests how “SWARMs,” which involve acceleration and simplification of root cause analysis processes, can augment organizational learning from adverse events.

**“SWARMing” to Improve Patient Care: A Novel Approach to Root Cause Analysis**

*Jing Li, MD, MS; Bernard Boulanger, MD, MBA, FACS; Jeff Norton, BSME, MSME; Audrey Yates, MSIE, SSBB; Colleen H. Swartz, DNP, DrPH; Ann Smith, MPA; Paula J. Holbrook, RN, BHS, JD, CPHRM; Mary Moore, RN, BSN, CPPS; Barbara Latham, RN, MSN, CHCQM; Mark V. Williams, MD*

At the University of Kentucky HealthCare, Lexington, Kentucky, an interdisciplinary team undertook thoughtful analysis of adverse or other undesirable events reported by frontline staff. Incident reporting increased by 52 percent—from an average of 608 incidents per month (June–December 2011) to an average of 923 (January–May 2014). The observed-to-expected mortality ratio decreased by 37 percent—from 1.17 (October 2010) to 0.74 (April 2015).

**Methods, Tools and Strategies**
The Family Caregiver Activation in Transitions Tool: A New Measure of Family Caregiver Self-Efficacy

Eric A. Coleman, MD, MPH; Kelly L. Ground, BS; Andrew Maul, PhD

The Family Caregiver Activation in Transitions™ (FCAT™) tool was developed to guide the care team in better understanding patient and family needs. The FCAT tool has the potential to guide interventions intended to enhance family caregiver preparation and confidence and thereby positively influences clinical practice during care transitions.

Departments: Tool Tutorial
Development of “SWARM” as a Model for High Reliability, Rapid Problem Solving and Institutional Learning

Eric A. Williams, MD, MS, MMM; De Ann Nikolai, BA, MT-BC; Lauren Ladwig, BSN, RN, CCRN; Carol Miller, RN, CPHQ; Elizabeth Fredeboelling, MSN, RN, NEA-BC

The pediatric ICU at Texas Children’s Hospital, Houston, Texas, created a unit-based mechanism for identification of issues that might be outside the scope of the institutional safety reporting structure. The multistep SWARM process started with electronic entry submission and concluded with communication of solutions such as practice or policy changes to caregivers. Between November 2010 and May 2014, 170 SWARMs were reported, entailing 244 problems and 190 solutions.

Rapid Response Systems
Implementing an Obstetric Emergency Team Response System: Overcoming Barriers and Sustaining Response Dose

Michael G. Richardson, MD; Kim A. Domaradzki, RN; Dennis T. McWeeney, DO

A high-risk obstetrical unit at Vanderbilt University Medical Center, Nashville, Tennessee, created an obstetric emergency team (OBET) response system. Several unique features—communication system, response team composition and interprofessional leadership support—may have promoted staff acceptance and use. Response dose data for the April 2010–March 2013 period demonstrated near-linear quarterly increases over time.
Forum

Physician Motivation: Listening to What Pay-for-Performance Programs and Quality Improvement Collaboratives Are Telling Us

Kurt R. Herzer, MSc; Peter J. Pronovost, MD, PhD

Intense debate surrounds the issue of whether financial incentives should be used to motivate clinicians to improve performance. Yet clinicians' intrinsic motivation is not enough to improve quality. Five recommendations are provided on how to better leverage intrinsic motivation to drive quality improvement.

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