Collecting CALNOC Data

Presented on Behalf of the CALNOC TEAM
by
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Getting Started—First Step

• Interested hospitals should contact Patricia McFarland, CALNOC Executive Officer (patricia.mcfarland@calnoc.org).
• Oregon and Washington sites contact Gladys Campbell at Washington State Hospital Association (WSHA) as a first step (Gladys@wsha.org)
Getting Started with CALNOC—Next Steps

- Complete the “CALNOC Hospital / Health System Site Agreement” and….
- CALNOC hospital demographic sheet and submit to wendy.smolich@calnoc.org to receive access to the CALNOC website.
- Receive Facility Code Number (confidential) and “Welcome” email from Data Team with Codebooks and essential “start up” information.

CALNOC Uses the Codebooks to Inform and Guide

Collaborative Alliance for Nursing Outcomes Project

CODEBOOK Part I

Coordinating and Using CALNOC Data in the Hospital Setting

Acute Care Version
January 1, 2010 Revision

CODEBOOK Part II:
Data Capture and Submission

Acute Care Version

January 1, 2010

Collaborative Alliance for Nursing Outcomes Project
Getting Started with CALNOC: Role of the Site Coordinator

• Define / Select your CALNOC Site Coordinator and refer to Codebook 1 for an introduction to the role definition.

• Attend an orientation or access the CALNOC website for the introductory tutorials.

Use Codebook I to Get Started

Codebook I:
• Informs the Chief Nurse Executive about CALNOC, and
• Provides the Site Coordinator and Clinical Leadership with critical information to develop CALNOC teams and initiate data collection.
The CALNOC Site Coordinator Tool Kit

Codebook Part I includes a Site Coordinator Tool Kit to use as a guide as you move through Part I & II of the Codebooks. You and your team will find these to be excellent references and resources!

CALNOC Structural Nursing Measures

- Hours of nursing care per patient day
  - RN HPPD
  - LPN HPPD
  - UAP HPPD
- Skill Mix*
- % Contract Hours
- Ratios*
  *calculated by CALNOC
- Voluntary Turnover Rate
- RN Characteristics
  - Education
  - Certification
  - Years of Experience
- Unit Rate of Admissions, Discharges and Transfers
CALNOC Process Measures

- Falls & Hospital Acquired Pressure Ulcers
  - Risk assessment
  - Time since last risk assessment
  - Risk Score (Pressure Ulcers)
  - Risk Status
  - Prevention protocols in place

- Medication Administration Accuracy Safe Practice Adherence

- PICC Line Insertion Practices (who inserted, where, presence of a dedicated team)

CALNOC Outcome Measures

- Hospital Acquired Pressure Ulcer Rate by Stage
- Fall Rate & Injury Fall Rate
- Restraint Prevalence Rate
- Central Line-Associated Blood Stream Infections in PICC Lines
- Medication Administration Accuracy Nurse Safe Practice Findings and Error Rates
About Code Book Updates: General Information

- CALNOC revises the codebooks when key nursing indicators are changed—check the website to access the latest version.
- Everything in the codebook is also in the website tutorials for training purposes.
- An Executive Summary of Changes is in the front of all new versions to highlight new content.
- CALNOC Codebook updates are aligned with both the National Database for Nursing Quality Indicators (NDNQI’s) Guidelines for Data Collection and the National Quality Forum (NQF) Endorsed Standards effective 2009.

Codebook Revision: Version 2010

- All data collected after January 1, 2010 uses the CALNOC Codebook version 2010 definitions, guidelines, and data collection tools.
- Please review the Executive Summaries in Codebook Parts 1 and 2 to highlight any changes that have been made.
- Current Codebooks are available on the CALNOC website under the Data/Codebook tab.
Use Codebook Part II to Collect and Submit Data

Codebook Part II has definitions, coding guidelines, data submittal instructions, and key references for each indicator in the CALNOC portfolio.

Staffing, Skill Mix and Patient Care Hours
Staffing Indicator Definition

Definition:
Nursing care hours are the productive* hours worked by the nursing staff who have direct patient care responsibilities and are included in the staffing matrix or who provide > 50% direct patient care.

*Exclude other hours paid for any indirect care and/or non-productive time such as sick time, vacation, education leave, or committee time.

Staffing Indicator Data Sources

• Payroll or staffing records may have this information, so work with finance, human resources, and the staffing office.
• The records may not be maintained on a monthly basis, so refer to Codebook Part II for a method to calculate hours.
Staffing Indicator Coding: Key Concepts

- CALNOC collects information for the RN, LVN, “all others” in the nursing care matrix.
- Outside staff from registries or agencies are calculated the same way.
- Sitter hours are reported separately; exclude sitters on a legal psychiatric hold or paid by family to assist with non-clinical care.

To assure accurate unit calculations, additional items that accompany the staffing data are:
- Total patient days per calendar month (not pay period).
- Unit based admissions, discharges, or transfers during the month (ADT).
- Voluntary turnover: voluntary uncontrolled separation per month, for RNS, LVNs, and CNAs.
New Staffing Related Language

• The 2010 Version of the Codebook has no new definitions but there are a few clarifications, such as:
  – Transfers should include actual transfers to another unit or level of care requiring RN assessment, not patient activity in the course of the day (i.e., do not include transfers to and from procedures, tests or treatments.)

Hospital Acquired Pressure Ulcers (HAPU) Incidence Rates

• California Hospitals must report all Stage 3+ HAPU events to the California Department of Public Health (CDPH).
• CALNOC has added a column in the Skill Mix file for each unit/each month to report the number of Stage 3+ HAPU events.
• CALNOC definition matches CDPH definition.
• This HAPU report is in addition to the CALNOC HAPU prevalence study.
<table>
<thead>
<tr>
<th>Monthly Reports</th>
</tr>
</thead>
</table>
| Facility Code   | Number (fcn)  
| Month           | Year (yr)     
| Numeric Code    | (for example: 1, 2)  
| Total RN Hours: | regular + contract (TotalRN Hours)  
| Total Contracted RN Hours only (TotalContractedRNHours)  
| Total LVN Hours: | regular + contract (TotalLVNHours)  
| Total Contracted LVN Hours only (TotalContractedLVNHours)  
| Total Non-RN/LVN Hrs: | regular + contract (TotalNonRNLVNHours)  
| Total Contracted Non-RN/LVN Hours only (TotalContractedNonRNLVNHours)  
| Total Patient Days for Month (TotalNumberPatientDays)  
| Total Sitter Hours (Sitter)  
| Total # Admitted (Total_Admitted)  
| Total # Discharged (Total_Discharged)  
| RN Voluntary Turnover (Total_RN_Vol_Turnover)  
| LVN_Aide voluntary Turnover (Total_LVN_Aide_Vol_Turnover)  
| RN # Employees (RN_No_Employees)  
| LVN_Aide # of Employees (LVN_Aide_No_Employees)  
| Total HAPU3+ Reported (HAPU3+Report)  

**Falls**

*(Per 1000 Patient Days)*
Falls Indicator Definition

Definition: The rate per 1000 patient days at which patients experience an *unplanned descent to the floor*.

- Data Sources: Fall data can be extracted from risk data, incident reports, or unusual occurrence reports.
- If incident reports do not include information about the patient’s risk or interventions, a chart review may be required.
- Tip: Align your incident reporting system with CALNOC definitions to avoid chart review.

Falls Indicator Coding: Key Concepts

- All unplanned descents to the floor are reported and described by type of fall, level of injury or no injury, and circumstances (observed, assisted, restrained at the time of the fall). Include assisted falls—when a staff member attempts to minimize the impact of the fall it is still a fall.
- Key processes that are assessed include the presence of an initial risk assessment and prevention plans.
- Coding falls: For each patient that falls, assign a consecutive number for a month. If a patient falls a second, or third time in the month, repeat their number.
New Falls Related Language

- Level of injury may not be apparent in the initial report—method to follow up on patient’s condition after 24 hours must be established in order to ensure level of injury data is captured and submitted to CALNOC.
- Code as “repeat fall (any unit)” if patient previously fell on any other unit or department.
- Johns Hopkins risk tool added to references.

Submit Patient Days (On the Skill Mix File) to Submit Fall Data

- **Patient Days** are required for CALNOC to calculate the rate of falls per 1000/patient days. Report **Patient Days** for the **Calendar Month** even if not collecting other skill mix data.
- Skill Mix Indicator **Patient Days** is entered and submitted on the Skill Mix Excel Data Submission File.
- Email file to datasubmit@CALNOC.org.
| Facility Code Number (fcn) | Month (1-12) | Year | Unit Numeric Code (unit_code) | Total RN Hours: regular + contract (TotalRN Hours) | Total Contracted RN Hours only (TotalContractedRNHours) | Total LVN Hours: regular + contract (TotalLVNHours) | Total Contracted LVN Hours only (TotalContractedLVNHours) | Total Non-RN/LVN Hrs: regular + contract (TotalNonRNLVNHours) | Total Contracted Non-RN/LVN Hours only (TotalContractedNonRNLVNHours) | Total Patient Days for Month (TotalNumberPatientDays) | Total Sitter Hours (Sitter) | Total # Admitted (Total_Admitted) | Total # Discharged (Total_Discharged) | RN Voluntary Turnover (Total_RN_Vol_Turnover) | LVN_Aide voluntary Turnover (Total_LVN_Aide_Vol_Turnover) | RN # Employees (RN_No_Employees) | LVN_Aide # of Employees (LVN_Aide_No_Employees) | Total HAPU3+ Reported (HAPU3+Report) |
|--------------------------|--------------|------|-------------------------------|---------------------------------------------------|---------------------------------------------------|---------------------------------------------------|---------------------------------------------------|---------------------------------------------------|---------------------------------------------------|----------------------------------------|-------------------|-------------------------------|------------------------------------------|--------------------------|---------------------------------|-------------------------------|-------------------------------|---------------------------------|---------------------------------|

**Hospital Acquired Pressure Ulcers and the Prevalence Study**

CALNOC

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Hospital Acquired Pressure Ulcers (HAPU) Definition

- **Definition:** A pressure ulcer is localized injury to the skin and/or underlying tissue usually over a bony prominence, as a result of pressure, or pressure in combination with shear and/or friction. (National Pressure Ulcer Advisory Panel, NPUAP, 2009)

(HAPU) Definition*

Pressure ulcers may be located over bony prominences or under a medical device or equipment. They are staged according to the extent of observable tissue damage. Only pressure related *skin injury* is included (NPUAP-AHCPR Ulcer Stages I-IV).

*CALNOC is the measure developer for the National Quality Forum HAPU measure and works closely with The Joint Commission, who serves as the measure “steward”.
HAPU Updates are Scientifically and Clinically Driven

CALNOC closely monitored the National and European Pressure Ulcer Panel 2009 review of definitions, clinical guidelines, and issued an update.

HAPU Prevalence Studies

- CALNOC uses a Prevalence Study methodology, which is a “Snapshot” of pressure ulcers on a selected day
- Pressure Ulcers are measured as the percent of patients with stage I, II, III, IV, unstageable ulcers, and deep tissue injury (DTI). Use updated codebooks for definitions.
- Pressure ulcer prevalence will be calculated by the CALNOC database.
HAPU Prevalence Data Sources

- **Prevalence Study Procedure**: See Part I of the CALNOC Codebook for details of the CALNOC pressure ulcer prevalence study procedure.
- The HAPU Prevalence Tool has been redesigned and only the new version can be used after January 1, 2010.
- Contact the CALNOC Data Control Coordinator Ruth.Parrales@cshs.org for the forms.

Planning A Prevalence Study

- Select a study coordinator, often the wound care nurse, to coordinate and train the team.
- Teams, rather than individuals, are the most practical and efficient way to conduct a prevalence study. Teams can combine clinical and non-clinical folks to split up work (turning patients and preparing for inspection, inspection, and chart review).
- Assign clinical experts with novice team members to ensure reliable data collection.
- Have all team members complete the CALNOC HAPU tutorial before participating in a study.
HAPU Updates: Key Concepts

There is new language to clarify questions about patient consent and exclusion criteria.

1) Patient consent is not required, since this work is required for ensuring patient care quality and safety performance improvement.

2) The terms “actively dying” and “medically unstable” are terms used to characterize patients who cannot safely be turned for physiological reasons and is more clearly defined in the Codebook Part II.

New HAPU Related Language

Questions concerning prevention protocols for patients “at risk” at the time of prevalence study have been designed to better assess clinical interventions that are evident to the survey team, including:

– Pressure redistribution,
– Routine re-positioning,
– Nutritional support,
– Moisture management.
Coding Improvements

• “Day of first staff discovery/documentation” changed to 3 category “bubble” coding:
  – Within 24 hours of admission,
  – Day 2 (24-48 hours after admission), or
  – After Day 2 (more than 48 hours after admission).
• Variable removed: “Stage of worst pressure ulcer at discovery/documentation” no longer collected.

The CALNOC Pressure Ulcer Tutorial
Specific Guidelines for the Pressure Ulcer Tutorial©

• The Pressure Ulcer Tutorial is a valuable tool for educating staff regarding assessment, staging and prevention of pressure ulcers. The illustrations, photos and graphics presented in the tutorial are subject to misinterpretation when separated from the overall tutorial content. Because of this, CALNOC strongly urges member hospitals to utilize the tutorial in its entirety and NOT extract or download portions of this copyrighted material.

Log on to Ulcer Tutorial Section of CALNOC website (www.CALNOC.org)

Use your hospital’s hospital-wide logon and password. (See your demographic sheet.) They will begin with TUTO followed by a number.
Topic 3: Pressure Ulcers and Staging: Stage I

Definition: Intact skin with non-submergence redness of a localized area usually over a bony prominence. Denuded or eroded skin may not have visible bleeding; its color may differ from the surrounding area.

Further Description: The area may be painful, firm, soft, warmer or cooler as compared to adjacent tissue. Stage I may be difficult to detect in individuals with dark skin tones. May indicate "at risk" persons (a harboring sign of risk).

For a comparison of Nonblanchable Erythema and Blanchable Erythema, click the link.

Indications compared to the opposite or adjacent area of the body also may include changes in one or more of the following:

- Skin temperature – increased warmth or coolness
- Tissue consistency – firm
- Tissue vibration – pain on pinching

Use with pressure ulcer.

To see examples of Stage I pressure ulcers, select a hyperlink:

Example 1
Example 2
Example 3

Topic 3: Pressure Ulcers and Staging: Stage III

Definition: Full thickness skin loss involving subcutaneous tissue; muscle or muscle are not exposed. S.e.g. may be present but does not indicate the depth of tissue loss. May include underlying fascia, muscle, and subcutaneous fat or connective tissue.

Further Description: The depth of a Stage III wound is determined by anatomical location: The bridge of the nose, ear, acromion and malleoli do not have subcutaneous tissue and stage III ulcers can be shallow. In contrast, areas of significant adiposity can develop extremely deep stage III pressure ulcers. Bone erosion is not visible or directly palpable.

To see examples of Stage III pressure ulcers, select a hyperlink:

Example 1
Example 2
Example 3
Enter your name and unit (If your facility requires it)

Complete All Questions Click “Submit”
Review Score
An 80+% is Required to Pass

Print Results Page for Record of Test

Physical Restraint Prevalence
Physical Restraint Indicator* Definition

• Any manual method or physical or mechanical device, material, or equipment attached or adjacent to the patient's body that he or she cannot easily remove that restricts freedom of movement or normal access to one's body.

*CALNOC is the measure developer and the U.S. steward of the Physical Restraint measure for the National Quality Forum and The Joint Commission and participated in the 2009 measurement review process.

Physical Restraint Indicator Data Sources

• This prevalence study is usually completed concurrently with the pressure ulcer prevalence study. Data collection tools are double sided:
  – Hospital, unit, date, and patient demographics and pressure ulcer study on front, continuing on back,
  – Restraint form on the back sharing.

• If restraint prevalence study is conducted independently of the HAPU study, the front side with the demographic information must also be completed and submitted with the restraint data.
Physical Restraint Coding: Key Concepts

• Prevalence: Percent of patients within a facility that have a restraint on the day of the prevalence study (# patients with restraint / # patients in study). Calculated by CALNOC from your data.

• Data elements collected include: type of restraint, Restraint category (non-behavioral or behavioral), presence of clinical justification, and whether a sitter was also present.

Restraints Form updated back page of Pressure ulcer survey 2010

Sampling Only
No New Restraint Language

• There were no substantive changes made to the Restraint indicator.
• The CMS compliance guidelines for hospitals has been added for additional clarity about restraints.
• Check the reference list for a few new sources of information.

RN Education, Experience and Certification
RN Education, Experience, and Certification

Definition:
• Annual report on all RNs on a unit (including those not in direct care). Includes information such as:
  – Age & Gender
  – Type of initial RN education
  – Highest education level completed
  – Years of experience in current practice area
  – Certification (e.g. regulatory agencies, specialty or professional organizations such as ANA, AWAHN, CCRN)

RN Education, Experience, and Certification Data Sources

CALNOC recommends using electronic sources if possible:
1. Extract CALNOC RN data if available from hospital records and submit via CALNOC Excel file, or
2. Conduct survey one time, making sure RNs enter a “unique identifier” that you designate (e.g., employee number, etc.),
3. Use CALNOC’s Excel file to enter and submit your data, or
4. Submit your data using scannable forms and request an Excel file of your survey data from CALNOC after processing is complete.
5. Update your Excel file each year and re-submit to entire file to CALNOC (include all RNs on CALNOC units).
RN Education, Experience, and Certification Coding

- Nurses employed on Non-CALNOC units may participate. Obtain a unit code number for the non-CALNOC units by contacting the Data Manager for coding instructions.
- Include all unit assigned Registered Nurses and the leadership.
- Submit the total number of RNs eligible to respond per unit using the Data Transmittal Sheet and via fax even if submitting data electronically. CALNOC will calculate your response rate.

Medication Administration Accuracy
Medication Administration Accuracy Indicator Definitions

- Medication administration error is defined as a dose administered differently than ordered on the patient’s medical record.

- Medication administration accuracy is operationally defined as the prevalence of errors in medication administration in relation to the number of dose opportunities.

Total Study Method: Observation & Error Review

Naïve observation methodology is a process whereby the observers do not know the actual medication order but observe the entire preparation and administration process.

Comparative record review is performed after observation is completed to determine number, type of errors and frequency of each type of medication error.
Recording Observed Data Elements

Administration Safe Practices—Enter No, Yes, or NA* for each observed medication in the center of the codesheet:

- Compares medication with the MAR
- Distracted or interrupted during preparation or administration
- Medication labeled throughout process
- Checks two forms of ID
- Explains medication to patient* only NA
- Charts medication immediately after administration

ALWAYS REFER TO THE DEFINITIONS

Catheter Association
Blood Stream Infections in Peripherally Inserted Central Catheter (CABSI-PICC)
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