HRET HIINnovation Roadshow

Nebraska Hospital Association

La Vista, NE

September 28, 2017

#WhyImHIIN
WIFI Username: AHA 2017
Passcode: 1234

Summary Disclosure & Accreditation Statement

AHA/HRET Hospital Improvement Innovation Network (HIIN)
HRET HIINnovation Roadshow
La Vista, Nebraska
September 28, 2017

The planners and faculty of the HRET HIINnovation Roadshow have indicated no relevant financial relationships to disclose in regard to the content of this presentation.

This activity has been planned and implemented in accordance with the accreditation requirements and policies of the Accreditation Council for Continuing Medical education through the joint providership of the American Board of Quality Assurance and Utilization Review Physicians, Inc. (ABQAURP) and the Health Research & Education Trust (HRET). ABQAURP is accredited by the ACCME to provide continuing medical education for physicians.

The American Board of Quality Assurance and Utilization Review Physicians, Inc. designates this live activity for a maximum of ***5.25 AMA PRA Category 1 Credits™***. Physicians should only claim credit commensurate with the extent of their participation in the activity.

ABQAURP is an approved to provide continuing education for nurses. This activity is designated for 5.0 Nursing Contact Hours through the Florida Board of Nursing, Provider # 50-94.

Agenda

Time	Session Title	Speakers
9:00-9:30 a.m.	**Welcome and Overview**	
	• Nebraska Hospital Association and HRET will provide an overview of the Partnership for Patients work, including our accomplishments to date and ambitious goals for the HIIN project.	**Kristin Bailey, RN, BSN, CPN** *Project Director, Clinical Quality- Nebraska Hospital Association* **Charisse Coulombe, MS, MBA, CPHQ** *Vice President, Clinical Quality- HRET* **Erin Craig, MPA** *Senior Program Manager-HRET*
9:30-10:00 a.m.	**Networking: Speed Dating**	
	• Evaluate your organization's progress in reducing hospital acquired conditions. • Share topic success factors and those requiring support.	**Maryanne Whitney, RN, CNS, MSN** *Improvement Advisor- Cynosure Health*
10:00-10:15 a.m.	*Morning Break*	
10:15 a.m.-12:00 p.m.	**The Way Up: How Four Cross-Cutting Strategies Can Reduce Harm Across the Board**	
	• Review four interventions to change care delivery: sedation management, hand hygiene, progressive mobility and medication appropriateness. • Discover tools and strategies for engaging multiple stakeholders in targeted improvement – from front-line staff to senior leadership.	**Maryanne Whitney, RN, CNS, MSN** *Improvement Advisor- Cynosure Health*
12:00-1:00 p.m.	*Break for Lunch*	
1:00– 3:15 p.m.	**Organizing and Leading for High Reliability**	
	• Summarize the characteristics of an organization on an HRO journey. • Assess where your organization is on the journey to high reliability. • Select one area where you will begin testing a new idea from this session. • Discuss how achieving the characteristics of HRO support your aims in the HIIN.	**Kathy Duncan, RN** *Faculty- Institute for Healthcare Improvement*
3:15 – 3:30 p.m.	**Reflection and Next Steps**	
	• Review themes from the day, opportunities for collaboration and next steps.	**Erin Craig, MPA** *Senior Program Manager-HRET*

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Nebraska Welcome and Data Review

Kristin Bailey, RN, BSN, CPN

Project Director, Clinical Quality

September 28, 2017

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Welcome to the HRET/NHA Roadshow

Today's Speakers

- **American Hospital Association – Health Research & Educational Trust (HRET)**
- **Cynosure Health**
- **Institute of Healthcare Improvement**

Nebraska Hospitals

- **Thirty-two HRET/NHA hospitals attending**

Housekeeping Issues

- **WIFI password**
- **Lunch**
- **Continuing Education Credits**

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Look how far we have come!!!

THEN	NOW
Hospital Engagement Network in 2012	**Hospital Improvement Innovation Network in 2017**
38 hospitals that participated with the NHA/HRET HEN	69 hospitals participating in Nebraska
2 to 6 topics	Reporting on 10 plus topics
1st Leadership Fellowships	Working with community partners-Great Plains QIN added to HIIN
Clarifying definitions and started reporting	Expanding to include front line, multiple areas and physicians
First Hospital site visits	Patient and Family Engagement
	Healthcare Disparities

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Making Progress towards Goals

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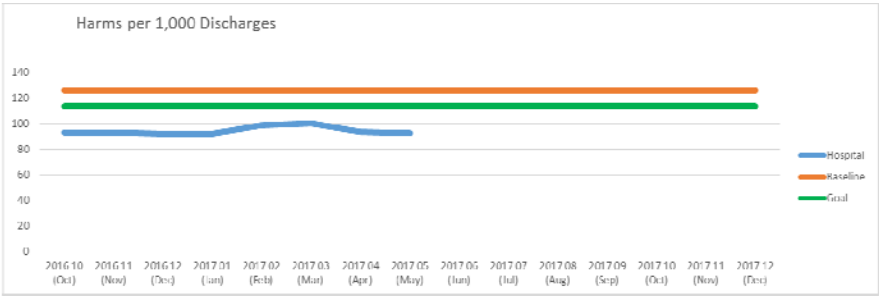
NHA Total Harm through May 2017

Most Recent Month Harms/1,000 Discharges	92.5
(% Improvement)	26.6%
Number of Harms Prevented to Date (*)	3123
Cost Savings to Date (*)	$21,279,877
Est. # Harms to Prevent to reach goal	0



The following measures are included in total harm: 3 ADE measures, CAUTI, CLABSI, C-Difficile, 4 SSI measures, Pressure Ulcers, Falls with injury, Sepsis Post op, VTE, VAC and Readmissions.

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Hitting Targets for Year 1 HIIN

Overall HIIN Goals

- **20% improvement on Patient Harm**
- **12% improvement on Readmissions**

Improvements through May 2017

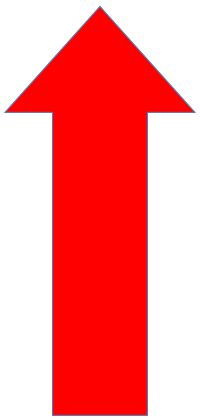
- 85% ↓ Workplace Violence
- 78% ↓ Workplace Patient Handling
- 72% ↓ SSI-Total Knee Replacements
- 68% ↓ Opioids-Adverse Drug Events
- 30% ↓ Hypoglycemic agents-Adverse Drug Events
- 29% ↓ SSI-Total Hip Replacements
- 24% ↓ Venous thromboembolism
- 22% ↓ Ventilator Associated Conditions
- 22% ↓ SSI-Colon Resections

Areas with some improvements

- 12% ↓ Falls with injury
- 9% ↓ Hospital onset Sepsis
- 7% ↓ Central Line Associated Blood Stream Infections
- 5% ↓ Readmissions

Topics with an increase in Harm

- Hospital Acquired Pressure Ulcers - 139%
- MRSA-113%
- SSI-Abdominal Hysterectomies-50%
- Post op Sepsis-39%
- C-Difficile-29%
- CAUTI-13%
- Anticoagulation-ADE-6%



Plans for the Upcoming Year

- Focus on topics where goals are not met
- Patient and Family Engagement
- Healthcare Disparities in your community

HIIN: THE ROAD TRAVELED AND JOURNEY AHEAD

Charisse Coulombe, MS, MBA, CPHQ
Vice President of Clinical Quality
American Hospital Association,
Health Research & Educational Trust

National Results on Patient Safety
(2015 compared to 2010 baseline)

- **21 percent decline in overall harm**
- **125,000 lives saved**
- **$28B in cost savings from harms avoided**
- **3.1M fewer harms over 5 years**

Source: Agency for Healthcare Research & Quality. "Saving Lives and Saving Money: Hospital-Acquired Conditions Update. Interim Data From National Efforts To Make Care Safer, 2010-2014." December 1, 2015.

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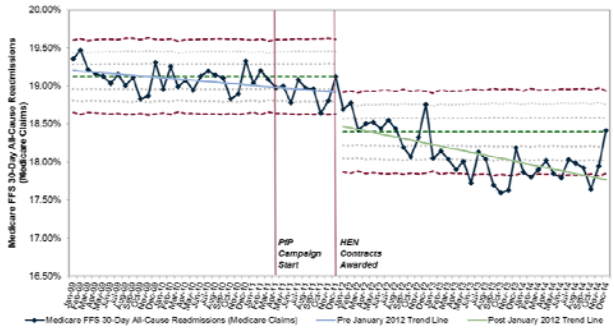
Medicare FFS 30-Day All-Cause Readmissions
(Medicare Claims)

- FFS Rate decreased 5.56 percent between calendar year 2010 and Q4 2014.
- AHRQ All-Payer All-Cause 30-Day Readmissions declined 2.6 percent from 2010 to 2013.



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CMS Networks Improving Patient Care

- **Partnership for Patients**
  - 4,000 Hospitals

- **Transforming Clinical Practices Initiative**
  - 140,000 Clinicians

- **End Stage Renal Disease Networks**
  - 6,000 Dialysis Facilities

- **Quality Innovation Networks – Quality Improvement Organizations**
  - 250+ Communities
  - 12,000+ Nursing Homes
  - 3,800 Home Health Organizations
  - 300 Hospice
  - 1,700 Pharmacies

- **MACRA and Quality Payment Program - Small, Underserved, Rural Support (SURS)**
  - Up to 200,000 Clinicians

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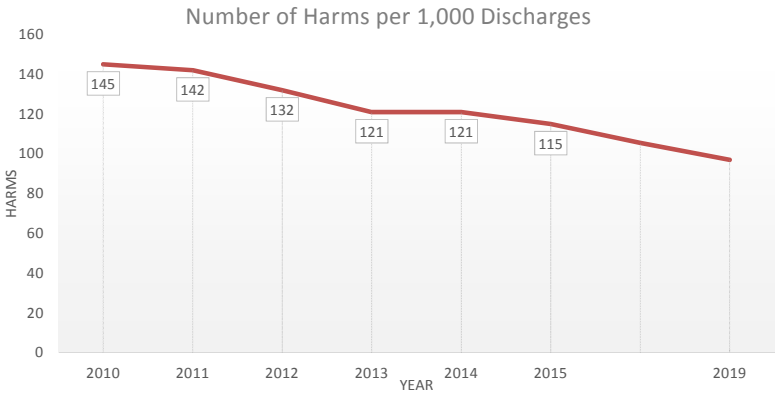
Sustaining and Accelerating Major Reductions in Harm



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AHA/HRET Original HEN Results

FINAL AHA/HRET HEN ESTIMATED TOTAL HARMS PREVENTED WITH COST SAVINGS

Topic	Estimated Harms Prevented [1]	Estimated Cost Savings
ADE	8,155	$24,465,000
CAUTI	2,805	$2,805,000
CLABSI	893	$15,181,000
EED	992 (NICU Admissions)	$7,811,000
Falls	1,331	$882,000
OB Harm	766	$705,000
Pressure Ulcers	4,655	$188,528,000
Readmissions	65,022	$572,714,000
SSI	4,860	$102,060,000
VAE/VAP	58	$1,218,000
VTE	3,255	$72,391,200
TOTAL	92,792	$988,760,000

DATA SOURCE:
Comprehensive Data System (CDS) (11/18/14); Data covers January 2012 through November 2014. Cost reference sources listed in PEC April 2014 Formative Feedback report appendices.

1 Harms prevented calculated at hospital level and then aggregated to HEN level (hospital compared to own baseline). Harm calculated only with months that have sufficient *n* (85 percent of hospitals reporting at baseline). Hospitals omitting months of data were determined to be negligible at HEN level.

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AHA/HRET HEN 2.0 Results

TOPIC	HARMS PREVENTED	COST/HARM	COST SAVINGS
ADE[1]	15,611	$5,000[1]	$78,054,063
CAUTI	505	$1,000	$505,078
CLABSI	439	$17,000	$7,469,333
EED	1,151	$9,732	$11,240,529
Falls	1,409	$12,965	$18,265,363
OB Harm[2]	4,336	$114 (with instrument) $197 (without instrument)	$753,627
Pressure Ulcers	1,122	$17,000	$19,077,915
Readmissions	8,040	$15,477	$124,440,097
SSI[3]	792	$21,000	$16,630,883
VAE	278	$21,000	$5,832,649
VTE	738	$8,000	$5,901,515
TOTAL	**34,422**	---	**$288,171,052**

** Totals may not match sum of individual topics due to rounding.*

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HIIN: Hospital Improvement Innovation Network

- Ctr for Clinical Standards and Quality
- HIIN funded out of Medicare Trust Fund

- Public-private partnership
- Set 20/12 goal all cause harm

- Tool: HIIN
- 16 contracts awarded

- Contracted with 32 state and regional hospital associations
- 1,700 + hospitals

Hospital leadership

Clinicians and front line staff (teams)

THE PATIENT

HIIN: Where We Are Going

Goals:

- **20%** **Overall reduction in hospital-acquired conditions** (baseline 2014)
- **12%** **Reduction in 30-day readmissions** (baseline 2014)

"America's hospitals embrace the ambitious new goals CMS has proposed," said Rick Pollack, president and CEO of the American Hospital Association (AHA). "The vast majority of the nation's 5,000 hospitals were involved in the successful pursuit of the initial Partnership for Patients aims. **Our goal is to get to zero incidents**. AHA and our members intend to keep an unrelenting focus on providing better, safer care to our patients -- working in close partnership with the federal government and with each other."

partnershipforpatients.cms.gov

2010	145 Harms/1,000 Discharges
2011	142 Harms/1,000 Discharges
2012	132 Harms/1,000 Discharges
2013	121 Harms/1,000 Discharges
2014	121 Harms/1,000 Discharges
***New Goal* 2019**	**97 Harms/1,000 Discharges**

Bold Aims For HIIN

Two base years to reduce all-cause inpatient harm by 20 percent and readmissions by 12 percent.

1. Be in action to support your patients and their families by committing to this project.
2. Work to reduce harm *across the board.*
3. Learn together by sharing your hospital stories – successes and opportunities.
4. Data is the foundation of all improvement at the unit level, hospital level, state and national level.
5. ***Accelerate***, ***align*** and ***amplify*** the work of the previous HEN projects.

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HRET HIIN Goals

Alignment with the Goals / Aims of the Partnership for Patients Program		
Recruitment		
Commitment to total # of hospitals the HIIN shall support		1,710
Bold Aim Milestones	**Year 1**	**Year 2**
Commitment to Reducing All-Cause Harm by 20%		
% Reduction of Adverse Drug Events	7%	20%
% Reduction of Central Line-Associated Bloodstream Infections	10%	20%
Bold Aim Milestones	**Year 1**	**Year 2**
% Reduction of Catheter Association Urinary Tract Infections	10%	20%
% Reduction of Clostridium difficile	7%	20%
% Reduction of Falls	7%	20%
% Reduction of Pressure Ulcers	10%	20%
% Reduction of Sepsis & Septic Shock	7%	20%
% Reduction of Surgical Site Infections	10%	20%
% Reduction of Venous Thromboembolism	7%	20%
% Reduction of Ventilator-Associated Events	7%	20%
Commitment to Reducing Harms Most Meaningful to the HRET HIIN		
% Increase in Hospital Culture of Safety	5%	20%
% Reduction in MDRO (i.e., MRSA)	5%	10%
Commitment to Reducing 30-day Readmissions by 12%		
% Reduction of Readmissions as a population-based measure	4%	12%
Total Proposed Impact		
Goal for Estimated Number of Harms Avoided Overall	26,635	73,150
Goal for Estimated Number of Lives Saved Overall	1,326	3,639
Goal for Estimated Cost Savings Overall	$233 million	$641 million

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HRET HIIN State Partners

1. Alabama
2. Arizona
3. Arkansas
4. Colorado
5. Connecticut
6. Dallas Fort-Worth
7. Delaware
8. Florida
9. Georgia
10. Idaho
11. Indiana
12. Kansas
13. Kentucky
14. Louisiana
15. Maine
16. Maryland
17. Massachusetts
18. Mississippi
19. Missouri
20. Montana
21. **Nebraska**
22. New Hampshire
23. New Mexico
24. North Dakota
25. Oklahoma
26. Puerto Rico
27. Rhode Island
28. Tennessee
29. Texas
30. Virginia
31. West Virginia
32. Wyoming

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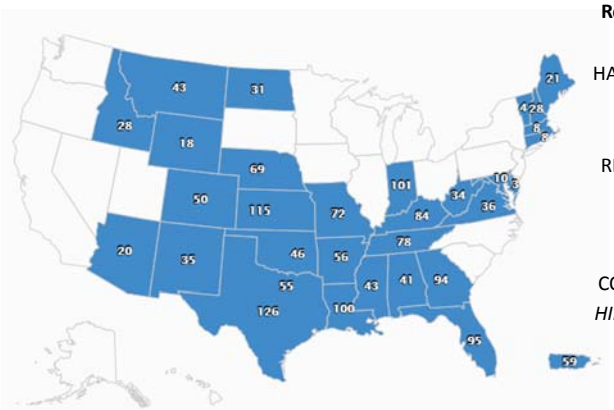
HRET HIIN Hospitals

1634 Hospitals

817 Rural
560 CAHs
816 Urban



Results to Date

29,447
HARMS AVOIDED

10,205
READMISSIONS AVOIDED

$271M
COSTS AVOIDED

HIIN Data (10/16 – 5/17)

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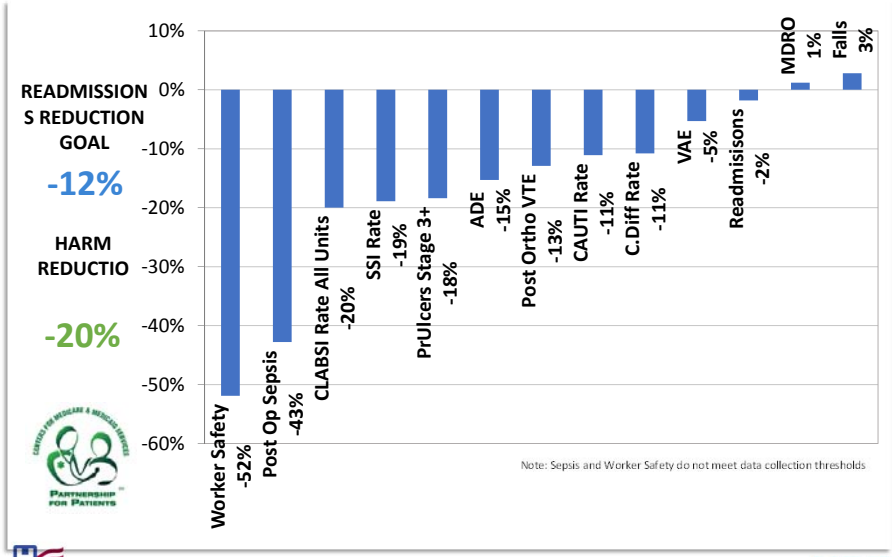
HRET HIIN PERCENT IMPROVEMENT, BASELINE – 2017

Year 1 Actual: Baseline compared to Oct 16 through June 2017, except readmission (through May 2017)

Data submitted as of August 1, 2017



HRET Nebraska
HIIN Results to date

	Harms Prevented	Costs Savings	Percent of hospitals meeting Year 1 Program Goals
ADE	2531	$12,651,574	58%
CAUTI	19	$19,446	64%
CLABSI	21	$354,180	69%
Falls	129	$1,666,760	45%
PrU	(18)	($307,998)	84%
SSI	54	$1,149,487	62%
c. Difficile	15	$148,939	59%
Sepsis	2	$0	33%
VAC	4	$79,064	75%
VTE	25	$199,757	85%
Readmissions	341	$5,284,054	51%
Total to date (1)	**4223**	**$21,279,877**	--

(1) Cumulative results through May 2017, based on data submitted as of Sept 26 2017

HRET Nebraska–
HIIN Year 1 results to date

NE Aggregate Results	# Hospitals	%	Baseline	Aggregate	Relative
ADEs - excessive anticoagulation	69	84%	3.78	3.94	4.1%
ADEs - hypoglycemia	69	83%	5.66	3.98	-29.7%
ADEs - opioids	69	83%	2.57	0.84	-67.5%
CAUTI Rate - all except NICUs	69	94%	0.82	0.94	14.5%
CAUTI Rate - ICUs except NICUs	13	100%	0.81	0.94	16.0%
C. diff rate Facility-wide	69	88%	4.09	5.25	28.4%
CLABSI rate - All	26	96%	0.67	0.63	-4.8%
CLABSI rate - ICUs	13	100%	0.97	0.63	-34.6%
Falls with injury	69	86%	1.2	1.03	-13.9%
MRSA bacteremia events	69	65%	0.02	0.04	102.4%
Pressure ulcer rate, stage 3+	17	100%	0.21	0.44	108.8%
Readmissions within 30 Days	69	94%	6.85	6.35	-7.3%
Sepsis Post-op Rate	62	98%	19.87	28.49	43.4%
SSI rate, colon surgeries	34	91%	6.87	5.23	-23.8%
SSI rate, abd hyst	36	94%	0.74	1.16	56.7%
Ventilator-associated condition rate	16	100%	4.58	3.62	-20.9%
Infection-related VAC rate	16	100%	1.09	0.88	-19.3%
Post-operative VTE or DVT	62	95%	2.37	1.81	-23.6%

Data submitted as of Sept 1 2017

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We're here to help!

Resources and Tools

Peer Sharing

Education and Skill Building

Data

NEW AND IMPROVED

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Education and Skill Building

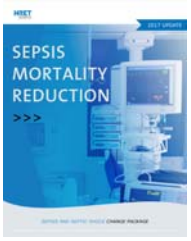
- Virtual Events – new formats!
  - Topic-specific and cross-cutting
  - Interactive and focused on participant feedback
- Safety Networks to Accelerate Performance (SNAP)
  - Small learning collaboratives to test emerging best practices
- UP Campaign
  - A cross-cutting approach to reduce harm
  - More information here: http://www.hret-hiin.org/topics/up_campaign/index.shtml
- Fellowship programs
- HIIN Roadshow (today!)

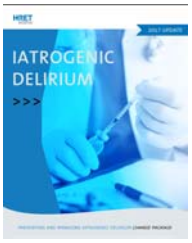
Resources and Tools

- Website and resource library: www.hret-hiin.org
  - Topic-specific information
  - Peer-shared and expert resources and tools
  - Evidence-based practice and guidelines

Change Packages and Top-Ten Checklists

- Jump-start your improvement projects





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LISTSERV® Collaboration

- Subscriber-based email group.
- Each email group covers a different topic or group of topics.
- Ideal for:
  - Peer-shared learning
  - Asking questions about barriers
  - Sharing data collection opportunities
  - Clarifications about measures or inclusion/exclusion criteria

Sign up today!

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Data Resources and Support

- Comprehensive Data System
  - Reports, tools, comparisons
- Encyclopedia of Measures
- Improvement Calculator
- How-to data videos

HRET HIIN Fellowships: QI and Patient & Family Engagement (PFE)

•20 fellows in Nebraska are participating:

- **QI: Foundations for Change Fellowship- 17 combined QI participants**
  - For new HIIN participants or those new to quality improvement.
- **QI: Accelerating Improvement Fellowship**
  - For QI-trained HIIN participants or those who have been focused on quality improvement and patient safety for more than five years.
- **PFE Fellowship- 3 participants**
  - For hospital staff and patient/family advisors seeking to support PFE at their institution and guide patient and family advisors on how to support QI and patient safety efforts.

•Details for each include:

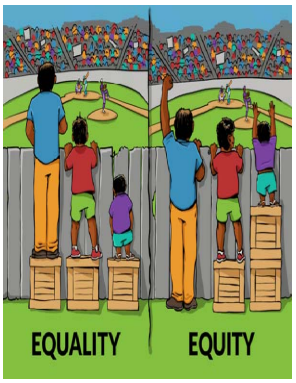
- Integrated learning across topics, QI and PFE fellowships.
- Deliverables throughout the fellowship to drive pace.
- Focus on peer-to-peer learning.
- Projects will highlight individual hospital progress toward HIIN project goals.
- Supported by virtual and on-site collaboration.

http://www.hret-hiin.org/fellowships

Patient / Family Engagement

- HRET Resources
  - PFE Fellowship: http://www.hret-hiin.org/fellowships/pfefellowship/index.shtml
  - Integrated into topical-specific education (e.g., using teach-back during discharge planning to reduce readmissions)
  - Peer sharing (LISTSERV®)
- Helpful References
  - CMS Person and Family Engagement Strategic Plan: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityInitiativesGenInfo/Person-and-Family-Engagement.html
  - Patient and Family Engagement Resource Compendium: http://www.hret-hiin.org/Resources/pfe/16/20160104-PFEcompendium.pdf

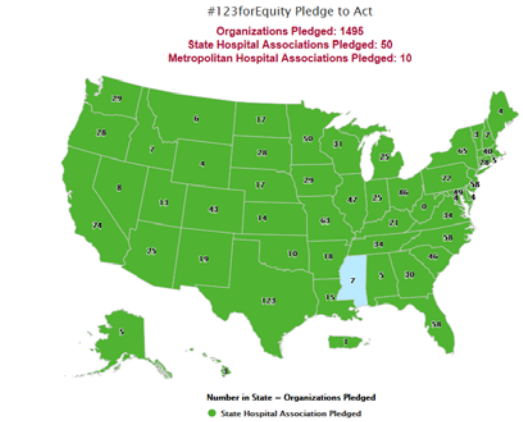
HRET HIIN Disparities / Health Equity

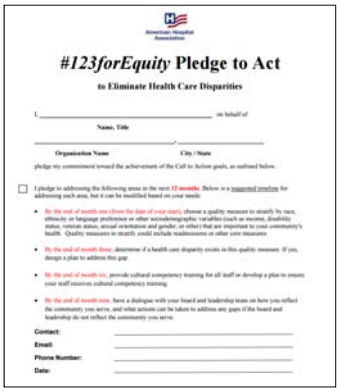


Source: http://culturalorganizing.org/the-problem-with-that-equity-vs-equality-graphic/

- HRET HIIN is committed to eliminating health care disparities and promoting health equity
- The evolving definition of diversity is inclusive of race, ethnicity, language preference, disability status, gender identity, sexual orientation, veteran status, and socioeconomic factors (http://www.hret-hiin.org/topics/healthcare-disparities.shtml)
- The HRET HIIN has partnered with the AHA's Institute for Diversity (http://www.diversityconnection.org/) and their #123forEquity Pledge to Act Campaign to:
  - ***Increase the collection, stratification and use of race, ethnicity, language preference and other sociodemographic data*** to improve quality and safety;
  - ***Increase cultural competency training*** to ensure culturally responsive care; and
  - ***Increase diversity in leadership and governance*** to reflect the communities served.
- Contact Raahat Ansari at ransari@aha.org for more information.

Health Equity: Get Involved!





#123forEquity Pledge to Act

to Eliminate Health Care Disparities

17 HRET HIIN Nebraska hospitals have taken the #123forEquity pledge

http://www.equityofcare.org/pledge/index.shtml

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Networking: Speed Dating

Maryanne Whitney, RN, CNS, MSN

Cynosure HEALTH

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WELCOME TO SPEED DATING

INSTRUCTIONS

- Fill out 2 post it notes

What I'm **PROUD** of in my work in the HIIN/HEN:

Name:
Hospital:

What I **NEED** to take my work in the HIIN to the next level:

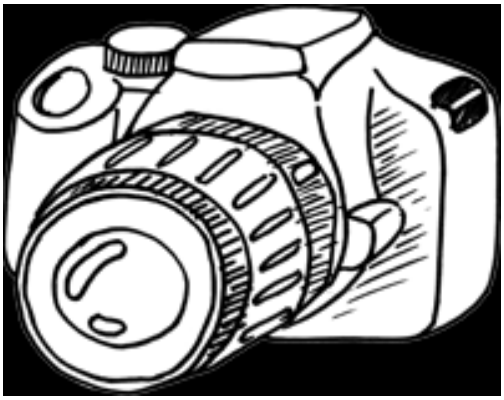
Name:
Hospital:

- Place your post it note on the corresponding Poster board

Meet a new friend. Exchange "prouds" and "needs" SWITCH!

What did you learn?

BREAK



#WhyImHIIN

The Way UP:
How Four Cross-Cutting Strategies Can Reduce Harm Across the Board

Maryanne Whitney, RN, CNS, MSN
NE Roadshow September 28, 2017

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The Way UP

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Questions to Run On

- How can we better engage front-line caregivers without creating additional burdens?
- What could introducing a simple, cross-cutting set of practices accomplish with your hospitals?
- How could you deploy a program like the UP Campaign with your hospitals and strengthen front-line engagement?

World Health Organization

SURGICAL SAFETY CHECKLIST (FIRST EDITION)

Before induction of anaesthesia ▸▸▸▸▸▸▸▸▸ Before skin incision ▸▸▸▸▸▸▸▸▸▸▸▸▸ Before patient leaves operating room

SIGN IN

- ☐ PATIENT HAS CONFIRMED
  - IDENTITY
  - SITE
  - PROCEDURE
  - CONSENT
- ☐ SITE MARKED/NOT APPLICABLE
- ☐ ANAESTHESIA SAFETY CHECK COMPLETED
- ☐ PULSE OXIMETER ON PATIENT AND FUNCTIONING
- DOES PATIENT HAVE A:
- KNOWN ALLERGY?
  - ☐ NO
  - ☐ YES
- DIFFICULT AIRWAY/ASPIRATION RISK?
  - ☐ NO
  - ☐ YES, AND EQUIPMENT/ASSISTANCE AVAILABLE
- RISK OF >500ML BLOOD LOSS (7ML/KG IN CHILDREN)?
  - ☐ NO
  - ☐ YES, AND ADEQUATE INTRAVENOUS ACCESS AND FLUIDS PLANNED

TIME OUT

- ☐ CONFIRM ALL TEAM MEMBERS HAVE INTRODUCED THEMSELVES BY NAME AND ROLE
- ☐ SURGEON, ANAESTHESIA PROFESSIONAL AND NURSE VERBALLY CONFIRM
  - PATIENT
  - SITE
  - PROCEDURE
- ANTICIPATED CRITICAL EVENTS
- ☐ SURGEON REVIEWS: WHAT ARE THE CRITICAL OR UNEXPECTED STEPS, OPERATIVE DURATION, ANTICIPATED BLOOD LOSS?
- ☐ ANAESTHESIA TEAM REVIEWS: ARE THERE ANY PATIENT-SPECIFIC CONCERNS?
- ☐ NURSING TEAM REVIEWS: HAS STERILITY (INCLUDING INDICATOR RESULTS) BEEN CONFIRMED? ARE THERE EQUIPMENT ISSUES OR ANY CONCERNS?
- HAS ANTIBIOTIC PROPHYLAXIS BEEN GIVEN WITHIN THE LAST 60 MINUTES?
  - ☐ YES
  - ☐ NOT APPLICABLE
- IS ESSENTIAL IMAGING DISPLAYED?
  - ☐ YES
  - ☐ NOT APPLICABLE

SIGN OUT

- NURSE VERBALLY CONFIRMS WITH THE TEAM:
- ☐ THE NAME OF THE PROCEDURE RECORDED
- ☐ THAT INSTRUMENT, SPONGE AND NEEDLE COUNTS ARE CORRECT (OR NOT APPLICABLE)
- ☐ HOW THE SPECIMEN IS LABELLED (INCLUDING PATIENT NAME)
- ☐ WHETHER THERE ARE ANY EQUIPMENT PROBLEMS TO BE ADDRESSED
- ☐ SURGEON, ANAESTHESIA PROFESSIONAL AND NURSE REVIEW THE KEY CONCERNS FOR RECOVERY AND MANAGEMENT OF THIS PATIENT

THIS CHECKLIST IS NOT INTENDED TO BE COMPREHENSIVE. ADDITIONS AND MODIFICATIONS TO FIT LOCAL PRACTICE ARE ENCOURAGED.

Checklist for Prevention of Central Line Associated Blood Stream Infections

Based on 2011 CDC guideline for prevention of intravascular catheter-associated bloodstream infections:
http://www.cdc.gov/hicpac/pdf/guidelines/bsi-guidelines-2011.pdf

For Clinicians:

Promptly remove unnecessary central lines

- ☐ Perform daily audits to assess whether each central line is still needed

Follow proper insertion practices

- ☐ Perform hand hygiene before insertion
- ☐ Adhere to aseptic technique
- ☐ Use maximal sterile barrier precautions (i.e., mask, cap, gown, sterile gloves, and sterile full-body drape)
- ☐ Perform skin antisepsis with >0.5% chlorhexidine with alcohol
- ☐ Choose the best site to minimize infections and mechanical complications
  - Avoid femoral site in adult patients
- ☐ Cover the site with sterile gauze or sterile, transparent, semipermeable dressings

Handle and maintain central lines appropriately

- ☐ Comply with hand hygiene requirements
- ☐ Scrub the access port or hub immediately prior to each use with an appropriate antiseptic (e.g., chlorhexidine, povidone iodine, an iodophor, or 70% alcohol)
- ☐ Access catheters only with sterile devices
- ☐ Replace dressings that are wet, soiled, or dislodged
- ☐ Perform dressing changes under aseptic technique using clean or sterile gloves

For Facilities:

- ☐ Empower staff to stop non-emergent insertion if proper procedures are not followed
- ☐ "Bundle" supplies (e.g., in a kit) to ensure items are readily available for use
- ☐ Provide the checklist above to clinicians, to ensure all insertion practices are followed
- ☐ Ensure efficient access to hand hygiene
- ☐ Monitor and provide prompt feedback for adherence to hand hygiene
  http://www.cdc.gov/handhygiene/Measurement.html
- ☐ Provide recurring education sessions on central line insertion, handling and maintenance

Supplemental strategies for consideration:

- 2% Chlorhexidine bathing
- Antimicrobial/Antiseptic-impregnated catheters
- Chlorhexidine-impregnated dressings

National Center for Emerging and Zoonotic Infectious Diseases
Division of Healthcare Quality Promotion

CDC

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Sepsis Checklist Board

Patient Name:_____ Patient ID:_____ Date:_____

If 2 or More Symptoms or Labs are Positive (Red), Contact Physician Immediately.

Pre-Disposition:	Symptoms:	Labs:
1. Immuno-Compromised	1. Orientation Change	1. Decrease % of Lymphocytes
2. Age < 5 or > 65	2. Temp. < 36C or > 38C	2. High or Low WBC Count
3. > Girth	3. Chills/Shaking	3. High or Low Platelet Count
4. Type 2 Diabetes	4. Warm Skin or Rash	4. Elevated Liver Enzymes
5. Renal Dx	5. Tachypnea > 20 bpm	5. Elevated CRP
6. Asthma Dx	6. Tachycardia > 100 bpm	6. Elevated Procalcitonin
7. Burn or Trauma Dx	7. Hypotension < 90/60	7. Elevated Lactic Acid >36 mg/dL
	8. Decreased Urine Output	8. Hypophosphatemia
		9. Coagulation Deficiencies
		10. Acidosis - pH < 7.35

Notes:

For best results use only Checklist Board™ markers, other markers may stain the surface. Use a clean dry cloth to wipe/clean after every use, do not use harsh chemicals. Order markers and Checklist Boards tm at 585-586-0152 or checklistboards.com.

8056LH25 v7

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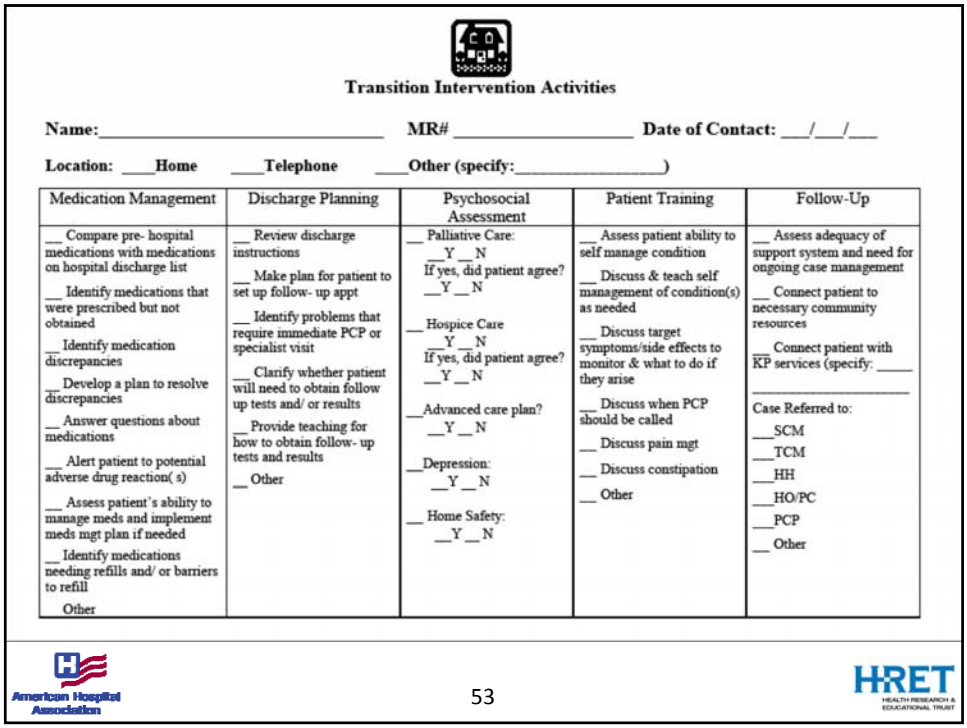

Transition Intervention Activities

Name:_____ **MR#** _____ **Date of Contact:** ___/___/___

Location: ____**Home** ____**Telephone** ____**Other (specify:**_____**)**

Medication Management	Discharge Planning	Psychosocial Assessment	Patient Training	Follow-Up
__ Compare pre- hospital medications with medications on hospital discharge list __ Identify medications that were prescribed but not obtained __ Identify medication discrepancies __ Develop a plan to resolve discrepancies __ Answer questions about medications __ Alert patient to potential adverse drug reaction(s) __ Assess patient's ability to manage meds and implement meds mgt plan if needed __ Identify medications needing refills and/ or barriers to refill Other	__ Review discharge instructions __ Make plan for patient to set up follow- up appt __ Identify problems that require immediate PCP or specialist visit __ Clarify whether patient will need to obtain follow up tests and/ or results __ Provide teaching for how to obtain follow- up tests and results __ Other	__ Palliative Care: __Y __ N If yes, did patient agree? __Y __ N __ Hospice Care __Y __ N If yes, did patient agree? __Y __ N __Advanced care plan? __Y __ N __Depression: __Y __ N __ Home Safety: __Y __ N	__ Assess patient ability to self manage condition __ Discuss & teach self management of condition(s) as needed __ Discuss target symptoms/side effects to monitor & what to do if they arise __ Discuss when PCP should be called __ Discuss pain mgt __ Discuss constipation __ Other	__ Assess adequacy of support system and need for ongoing case management __ Connect patient to necessary community resources __ Connect patient with KP services (specify: _____ _____ Case Referred to: __SCM __TCM __HH __HO/PC __PCP __ Other

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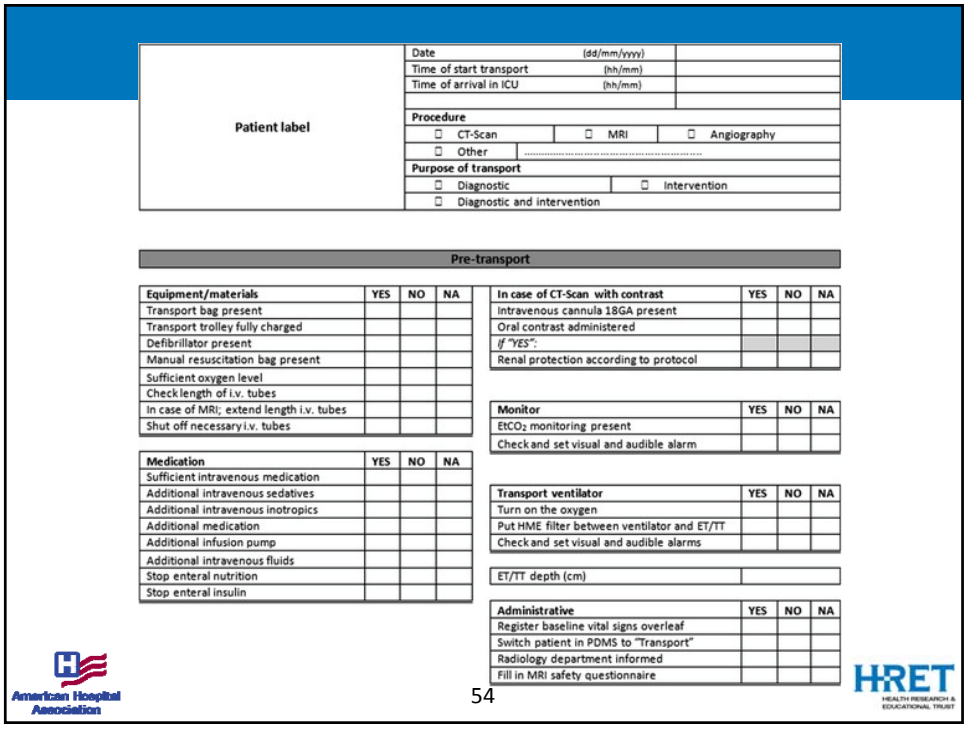

Patient label		
	Date (dd/mm/yyyy)	
	Time of start transport (hh/mm)	
	Time of arrival in ICU (hh/mm)	
	Procedure	
	☐ CT-Scan ☐ MRI ☐ Angiography	
	☐ Other	
	Purpose of transport	
	☐ Diagnostic ☐ Intervention	
	☐ Diagnostic and intervention	

Pre-transport

Equipment/materials	YES	NO	NA
Transport bag present			
Transport trolley fully charged			
Defibrillator present			
Manual resuscitation bag present			
Sufficient oxygen level			
Check length of i.v. tubes			
In case of MRI; extend length i.v. tubes			
Shut off necessary i.v. tubes			

Medication	YES	NO	NA
Sufficient intravenous medication			
Additional intravenous sedatives			
Additional intravenous inotropics			
Additional medication			
Additional infusion pump			
Additional intravenous fluids			
Stop enteral nutrition			
Stop enteral insulin			

In case of CT-Scan with contrast	YES	NO	NA
Intravenous cannula 18GA present			
Oral contrast administered			
If "YES":			
Renal protection according to protocol			

Monitor	YES	NO	NA
$EtCO_2$ monitoring present			
Check and set visual and audible alarm			

Transport ventilator	YES	NO	NA
Turn on the oxygen			
Put HME filter between ventilator and ET/TT			
Check and set visual and audible alarms			

ET/TT depth (cm)	

Administrative	YES	NO	NA
Register baseline vital signs overleaf			
Switch patient in PDMS to "Transport"			
Radiology department informed			
Fill in MRI safety questionnaire			

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Why the "UP" Campaign?

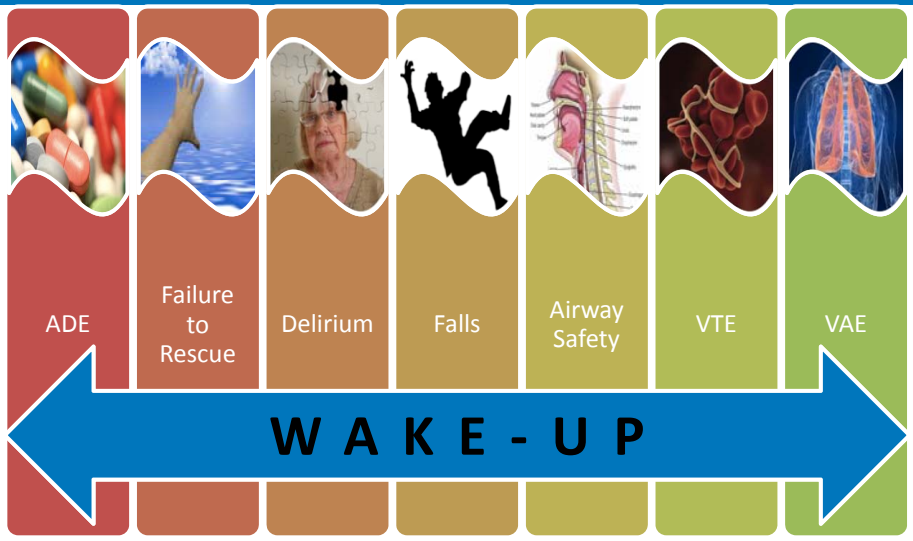
- Increases impact on harm reduction
- Generates momentum in your organization
- Focuses support from leadership
- Engages front line staff
  - connects the dots
  - creates a vision
- Applies throughout organization
- Simplifies patient safety implementation
- Help patients recover **faster** and with **fewer** complications

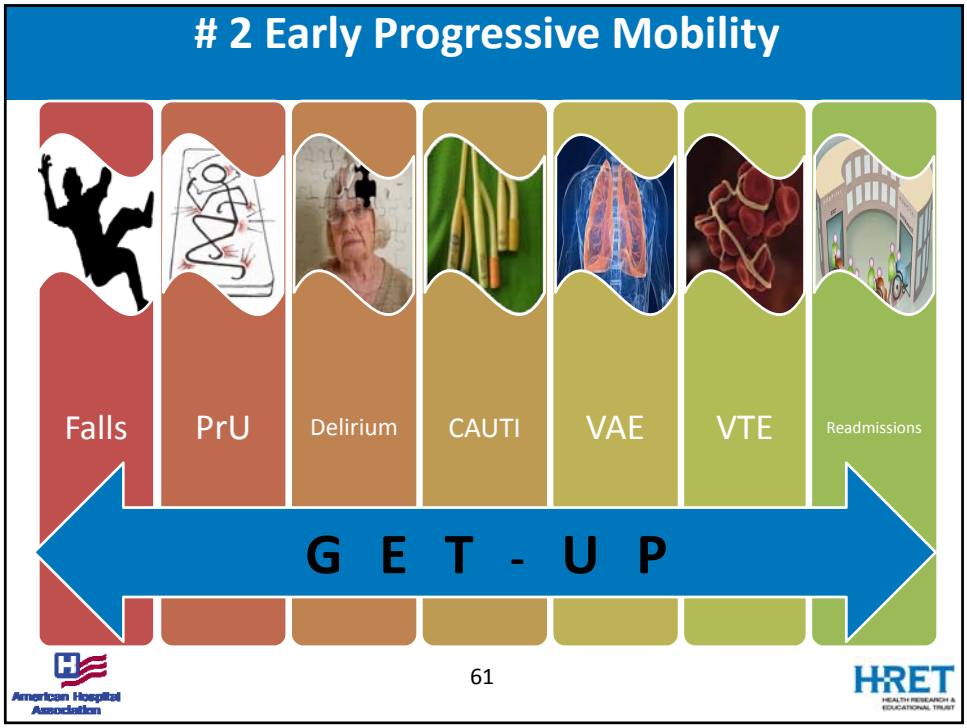
Can we streamline and simplify making it easier for front-line staff and still improve safety?

Objectives

- Outline the UP Campaign crosscutting interventions
- Develop messaging for the UP Campaign for your facility
- Identify essential next steps for WAKE-UP, GET-UP, SOAP-UP and SCRIPT-UP

1 Opioid & Sedation Management




2 Early Progressive Mobility
Falls
PrU
Delirium
CAUTI
VAE
VTE
Readmissions
G E T - U P
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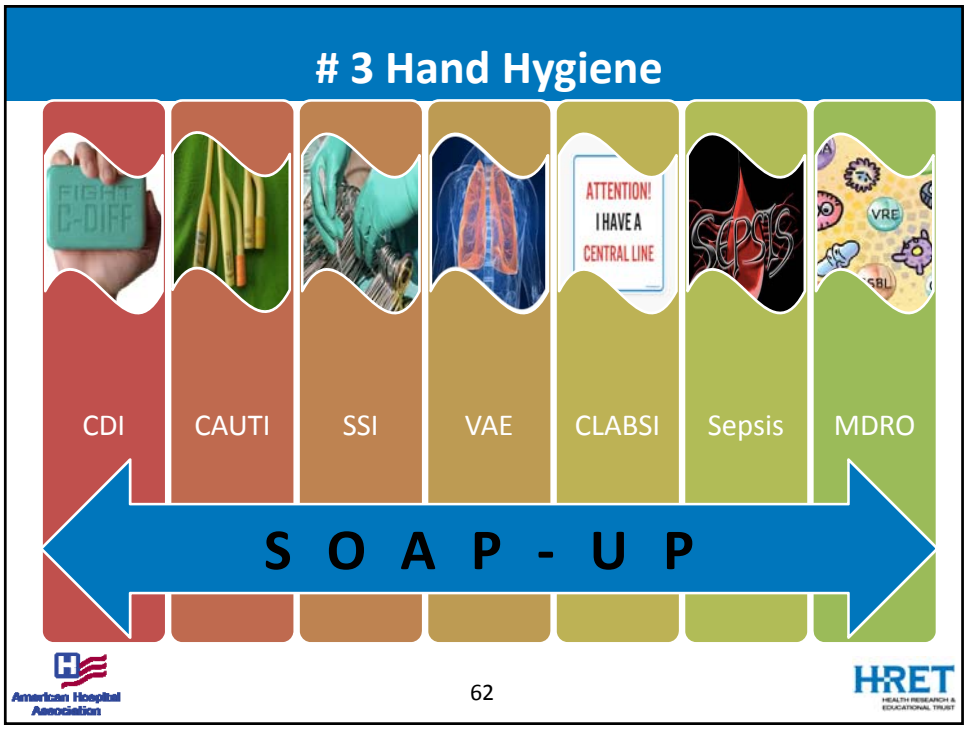
3 Hand Hygiene
FIGHT C-DIFF
ATTENTION! I HAVE A CENTRAL LINE
SEPSIS
VRE
CDI
CAUTI
SSI
VAE
CLABSI
Sepsis
MDRO
S O A P - U P
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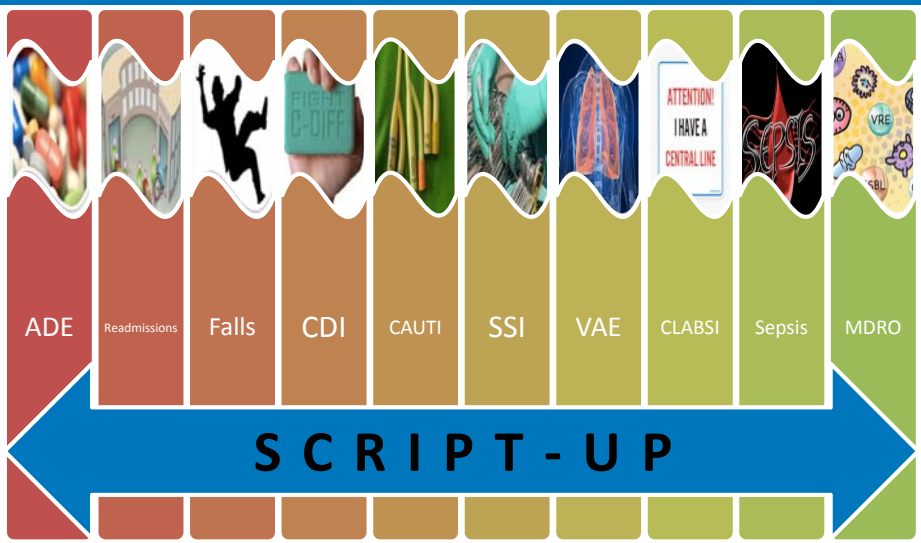
#4 Optimize Medications



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FOUNDATIONAL QUESTIONS:

1. Is my patient awake enough to get up?
2. Have I protected my patient from infections?
3. Does my patient need any medication changes?

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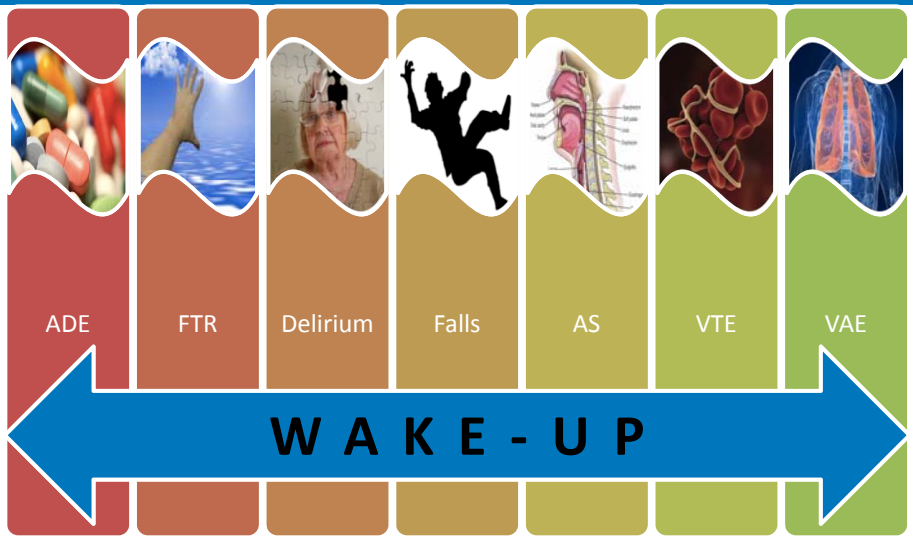
Activity

- Who has had success with:
  - Narcotic and sedation management?
  - Mobility?
  - Hand Hygiene?
  - Medication appropriateness?
- Pair up with your neighbor.

1 Opioid & Sedation Management



Sleep vs Sedation

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Not Just Sedatives and Opioids

- Antihistamines/anticholinergics
- Antipsychotics
- Some antidepressants
- Anti-emetics
- Muscle relaxants

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ICU Pitfalls of Sedatives and Analgesics

Sedatives and analgesics may contribute to:

- Increased duration of mechanical ventilation
- Length of intensive care requirement
- Impede neurological examination
- May predispose to delirium

Kollef M, et al. *Chest*. 114:541-548.
Pandharipande et al. *Anesthesiology*. 2006;124:21-26.

Med/Surg Pitfalls of Sedatives and Analgesics

- Over sedation
- Transfer to ICU
- Hypoxic encephalopathy
- Death

MUST DO's

WAKE-UP MUST DO's

1. Establish Expectations
2. Pair POSS & Pain
3. Manage with Multiple Modalities

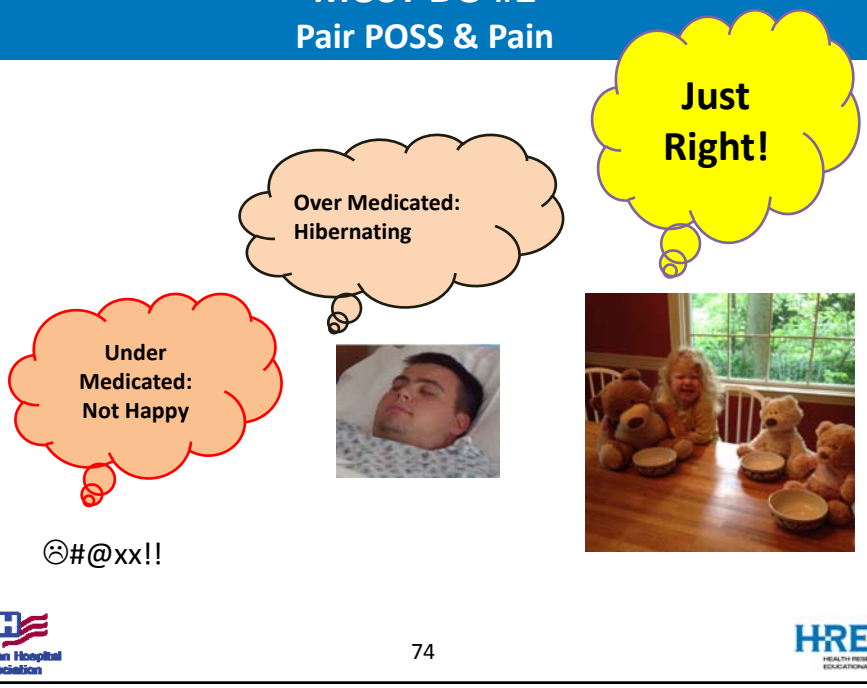
MUST DO #1
Establish Expectations

Goals of Pain Management:

- Relieve suffering
- Achieve early mobilization
- Reduce hospital length of stay

THE GOAL IS NOT ZERO PAIN!

MUST DO #2
Pair POSS & Pain



POSS AKA "GOLDILOCKS SCALE"

- S- Sleep, easy to arouse
- 1- awake and alert
- 2- slightly drowsy
- 3- frequently drowsy, drifts off to sleep during conversation
- 4- somnolent, minimal or no response to stimulation

Pasero Opioid-Induced Sedation Scale (POSS) With Interventions*

S = Sleep, easy to arouse
Acceptable; no action necessary; may increase opioid dose if needed

1 = Awake and alert
Acceptable; no action necessary; may increase opioid dose if needed

2 = Slightly drowsy, easily aroused
Acceptable; no action necessary; may increase opioid dose if needed

3 = Frequently drowsy, arousable, drifts off to sleep during conversation
Unacceptable; monitor respiratory status and sedation level closely until sedation level is stable at less than 3 and respiratory status is satisfactory; decrease opioid dose 25% to 50%[1] or notify primary[2] or anesthesia provider for orders; consider administering a non-sedating, opioid-sparing nonopioid, such as acetaminophen or a NSAID, if not contraindicated; ask patient to take deep breaths every 15-30 minutes.

4 = Somnolent, minimal or no response to verbal and physical stimulation
Unacceptable; stop opioid; consider administering naloxone[3,4]; stay with patient, stimulate, and support respiration as indicated by patient status; call Rapid Response Team (Code Blue) if indicated; notify primary[2] or anesthesia provider; monitor respiratory status and sedation level closely until sedation level is stable at less than 3 and respiratory status is satisfactory.

No discharge from PACU
No additional opioids

***Appropriate action is given in italics at each level of sedation.**

[1] If opioid analgesic orders or hospital protocol do not include the expectation that the opioid dose will be decreased if a patient is excessively sedated, such orders should be promptly obtained.
[2] For example, the physician, nurse practitioner, advanced practice nurse, or physician assistant responsible for the pain management prescription.
[3] For adults experiencing respiratory depression give intravenous naloxone very slowly while observing patient response ("titrate to effect"). If sedation and respiratory depression occurs during administration of transdermal fentanyl, remove the patch; if naloxone is necessary, treatment will be needed for a prolonged period, and the typical approach involves a naloxone infusion. Patient must be monitored closely for at least 24 hours after discontinuation of the transdermal fentanyl.
[4] Hospital protocols should include the expectation that a nurse will administer naloxone to any patient suspected of having life-threatening opioid-induced sedation and respiratory depression.

Two Scales are Better than One for Narcotic and Sedation Administration

PAIN ALONE

- Risk factors may be absent
- Objective?
- Dosage based on number or range
- Patients and families understand the numeric dosing

PAIN & POSS

- Two scales allow for safer dosing
- High pain scale with high POSS scale – no narcotics
- High pain scale low POSS - med dose

MUST DO #3
Multi-Modal Pain Management

Pharmacological and

Non-pharmacological

MULTIMODAL PAIN MANAGEMENT

- Combination of opioid and one or more other drugs
  - acetaminophen (Tylenol, others)
  - ibuprofen (Advil, Motrin IB, others)
  - celecoxib (Celebrex)
  - ketamine (Ketalar)
  - gabapentin (Gralise, Neurontin)
- Non-pharmacological interventions

www.mayoclinic.org/pain-medications/art-20046452

CAN WE MANAGE PAIN WITH NON-PHARMACOLOGIC METHODS?

What do we do at home?

Comfort measures:

- Pet therapy
- Warm compresses, blankets
- Ice packs
- Extra pillows
- Aromatherapy
- Massage
- Herbal tea
- Stress ball
- Music

DO COMFORT ITEMS HELP?

- These modalities can:
  - Reduce anxiety
  - Reduce pain
- Reducing anxiety can reduce pain
- Non-pharmacologic pain reduction methods reduce the need for pain medications

DO HOSPITALS OFFER THESE?

https://www.pvmc.org/patients-visitors/pain-comfort-menu

Platte Valley MEDICAL CENTER | SCL Health

http://www.hopkinsmedicine.org/the_johns_hopkins_hospital/services_amenities/services/pain-control-comfort-menu.html

JOHNS HOPKINS MEDICINE

POSITIVE RESULTS

- Pain scores
- Nausea scores
- Anxiety scores….

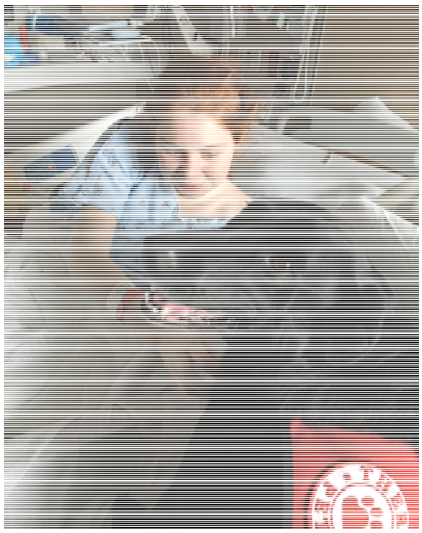
All decreased by more than 50%

NEXT: Looking to see if opioid usage and opioid ADEs are both decreased.

MULTI-MODAL THERAPY

Emma, age 13, had her 3rd surgery for a congenital foot deformity. Pain management was problematic, so both gabapentin and pet therapy were added to lower opioid doses with excellent results, allowing discharge to home 36 hours later.

CASE STUDY



Activity: What would you do?

- You have a post-op patient who has assessed his pain as an 8 on a scale of 1-10.
- When you assessed the POSS 30 minutes ago, he scored a 3.

- Pair up.
- How would you approach this patient and family?
- Formulate your plan.
- Try it out.
- Discuss at the table.

CHECK POINT

PREPARING FOR
THE UP CAMPAIGN:
SET UP TOOL

USE THIS TOOL TO ASSESS YOUR ORGANIZATION'S READINESS TO IMPLEMENT THE **UP CAMPAIGN.** DOES YOUR ORGANIZATION HAVE THESE PRACTICES IN PLACE? *If not, click on the links for more information.*

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WAKE UP

To reduce: ADE, Airway Safety, Delirium, Failure to Rescue, Falls, VAE and VTE

- ☐ Are the dangers of over sedation known?
- ☐ Is there a strong desire to keep sedation to a minimum?
- ☐ Have you selected evidence-based assessment tools such as:
  - ☐ STOP BANG (identifies patients at risk for obstructive sleep apnea)
  - ☐ PASERO OPIOD-INDUCED SEDATION SCALE (POSS)
  - ☐ RICHMOND AGITATION SEDATION SCALE (RASS)
- ☐ Have staff been educated on the use of the selected assessment(s) tool(s) and performance expectations?
- ☐ Is there a place to document the results of the assessment(s)?
- ☐ Are assessment targets established for each patient?
- ☐ Are the results from assessment(s) used to modify sedation levels?
- ☐ Is there a protocol in place to adjust sedation levels?

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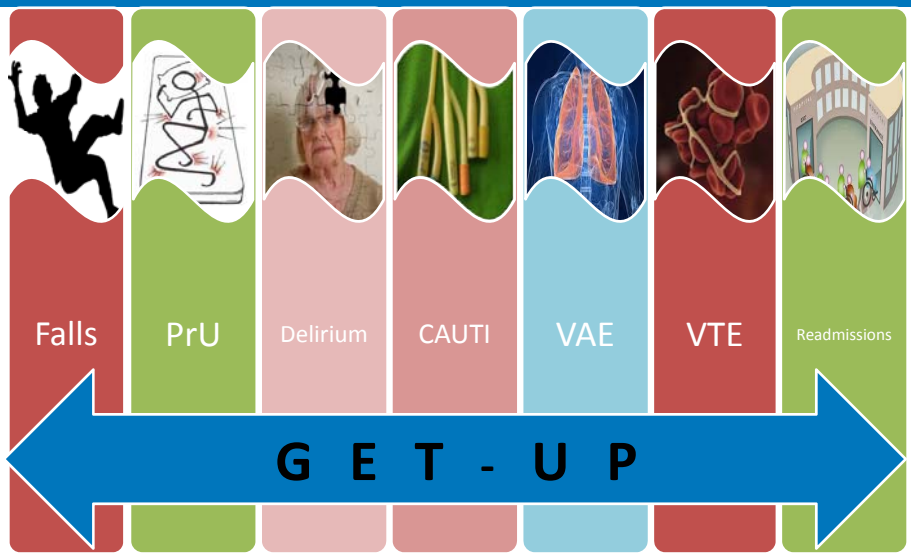
2 Early Progressive Mobility



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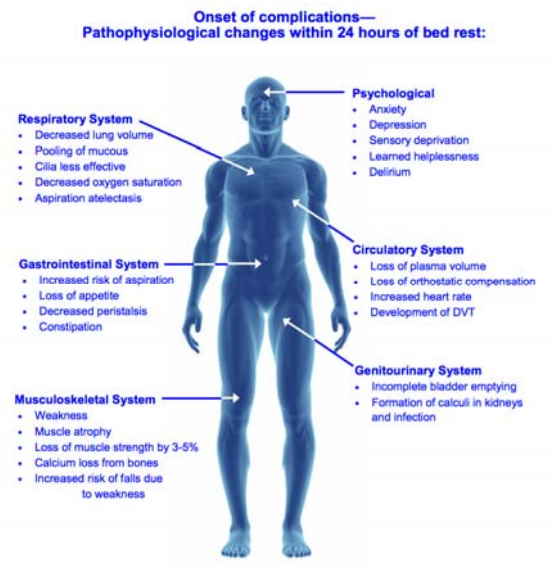
Pathophysiological changes within 24H of bed rest



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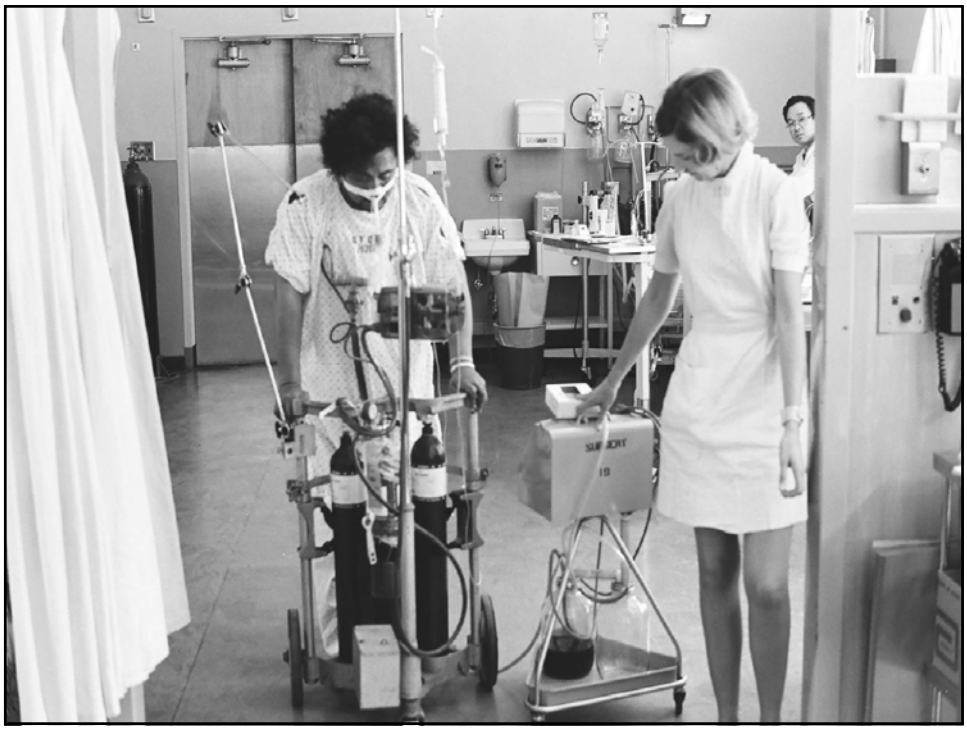

Cumulative impact on quality of life

- "New Walking Dependence" occurs in 16-59% in older hospitalized patients (Hirsh 1990, Lazarus 1991, Mahoney 1998)
- 65% of patients had a significant functional mobility decline by day 2 (Hirsh 1990)
- 27% still dependent in walking 3 months post discharge (Mahoney 1998)

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It's Simple

If they came in walking, keep them walking

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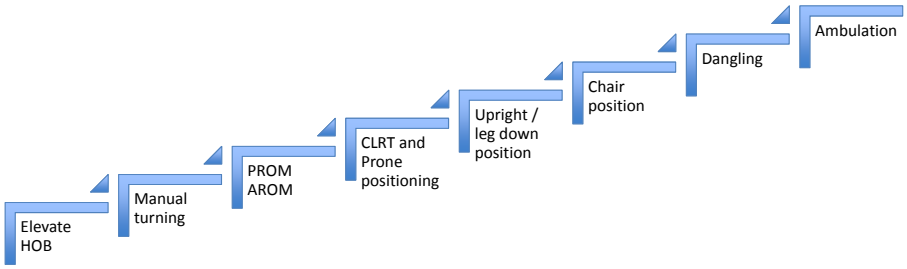
Use mobility to accelerate progress

"When am I going to walk? I walked yesterday. It's better than just being in the chair. I feel better when I am walking."

What is progressive mobility?

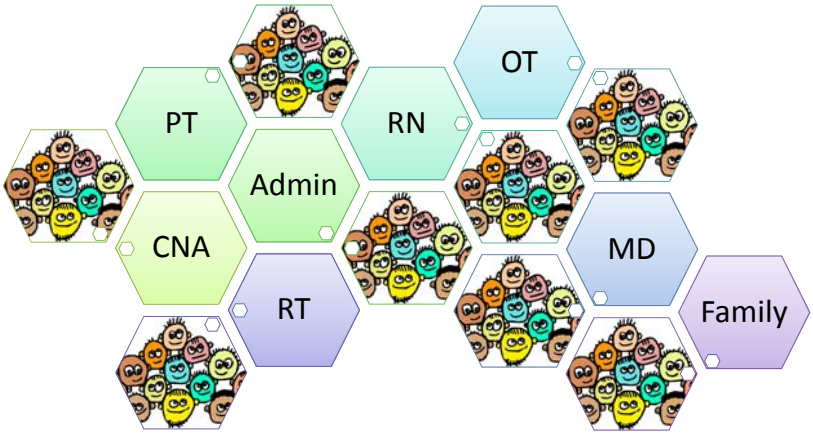
- Progressive mobility is defined as a series of planned movements in a sequential matter beginning at a patient's current mobility status with goal of returning to his/her baseline

(Vollman 2010)



Vollman, KM. Introduction to Progressive Mobility. Crit Care Nurs. 2010;30(2):53-55.

TEAMING UP TO MOBILIZE



MUST DO's

GET-UP MUST DO'S!

1. Walk in, walk during, walk out!
2. Belt and bolt!
3. Three laps a day keeps the nursing home away!

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MUST DO #1
Walk In, Walk During, Walk Out!

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MUST DO #1
Walk In, Walk During, Walk Out!

- Determine pre admission ambulation status
- Don't assume a frail appearance means weakness
- Use Get Up and Go test to assess ambulation skills

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Mobility begins on admission

Tier Level	Defining Characteristics	Intervention[a]
Tier 1: Nonambulatory	Patients who • require more than a one-person assist for ambulation/transfers • are unable to maintain weight on their lower extremities • require any form of lift equipment	Active range-of-motion exercises: • ankle pumps • heel slides • hip abduction • quad sets • shoulder flexion Passive range-of-motion exercises: • ankle dorsiflexion • hip flexion • hip abduction • shoulder flexion Sit on side of bed Get out of bed and into a chair with appropriate equipment
Tier 2: Ambulatory	Patients who • are able to ambulate independently • require a one-person assist with ambulation	Ambulate with or without assistance in the hallway as tolerated Get out of bed and into a chair for all meals

[a] To be performed three times a day (in accordance with a patient's ability).

Wood W, et al.(2014) A Mobility Program for an Inpatient Acute Care Medical Unit. http:www.nursingcenter.compdfjournalAID=2591440&an=00000446-201410000-00023&Journal_ID=54030&Issue_ID=2591321

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MUST DO #2
Belt and Bolt!

- Gait belts in every room
- Safe mobilization and patient handling training for nursing staff

See CAPTURE Falls Project Website for guidance: http://www.unmc.edu/patient-safety/capturefalls/learningmodules/index.html

Gait belts are used to help control the patient's center of balance.

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MUST DO #3
3 Laps a Day, Keeps the Nursing Home Away!

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Facing the Facts about Mobility

Mobility interventions are regularly missed

- Nursing perceptions
  - Lack of time
  - Ease of omission
  - Belief it is PTs responsibility
- Survey results
  - Concern for patients level of weakness, pain and fatigue
  - Presence of devices – IVs and Urinary Catheters
  - Lack of staff to assist

Doherty-King, B Bowers, B. How nurses decide to ambulate hospitalized older adults: development of a conceptual model. Gerontologist. 2011 Dec:51(6): 786-97

Tips for Promoting Mobility

- Order Modifications
  - Delete orders for
    - Bedrest
    - Ad lib
  - Replace with specific orders
    - Times, activities, distance
- Promote Team Mobility Management
  - Delegation of patient mobility
    - Replace sitters with a mobility aide
  - Rehab and Nursing face-to-face bedside handoffs
    - Document plans and progress on white boards

Skill building activity

- Pick a scenario
  1. Conversation with a nurse who is not ambulating his/her patient
  2. Conversation with a patient who is not interested in getting up
- Role play
  1. One person plays the nurse and the other plays the supervisor/manager
  2. One person plays the patient and the other plays the provider

CHECK POINT

GET UP

To reduce: CAUTI, Delirium, Falls, Pressure Ulcers/Injuries, Readmissions, VAE and VTE

- ☐ Are the negative effects of immobility known?
- ☐ Is there a strong desire to mobilize every patient to their highest ability?
- ☐ Do you have a mobility safety screen to determine when it is safe to mobilize the patient?
- ☐ Do you have a mobility protocol that emphasizes progressive mobility with a preference towards full mobility?
- ☐ Do you have the required resources, both human and equipment, to mobilize patients?
- ☐ Have staff been educated regarding performance expectations and the use of the safety screen and progressive mobility protocol?
- ☐ Is there a place to document the mobility safety screen results and the actual type and duration of mobility accomplished?

3 Hand Hygiene

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Hand-washing an OLD intervention

- Since 1847 we have understood that hand hygiene (HH) makes a difference in the spread of infections
  - Dr. Ignaz Semmelweis in Vienna – Childbed fever
  - Dr. Lister – OR
  - 1980's concepts of hand hygiene in health care emerged
  - 2002 alcohol based hand rub adopted
  - 2007-2008 WHO Global clean hands initiative
- Yet the average HH compliance is 48%

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We need to get it right!

- Protect our patients from HAI by performing HH.
- Promote patient and family engagement- give them permission to “speak up for clean hands.”
- Promote patient HH for patients.

http://www.cdc.gov/handhygiene/patients/index.html

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MUST DO's

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SOAP-UP Must Do's

1. Prompt Peer Performance
2. Track Quietly and Trend Loudly
3. Drive Drift Down

MUST DO # 1
Prompt Peer Performance

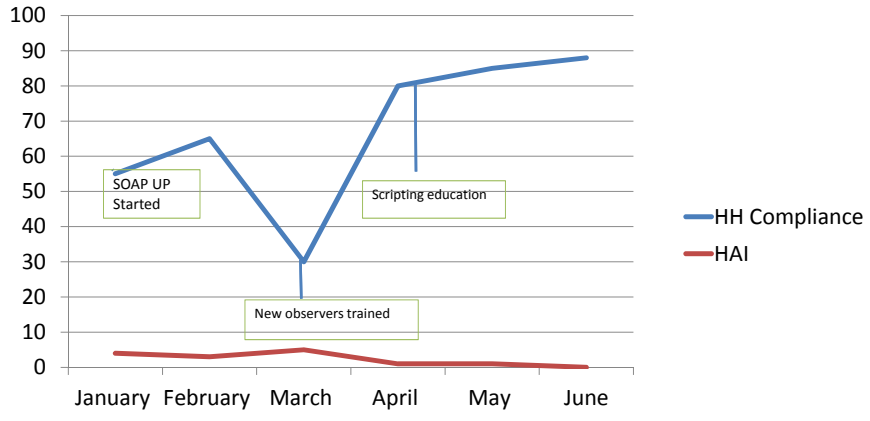
MUST DO #2
Track Quietly and Trend Loudly

Hand Hygiene

vs.

Healthcare-Associated Infections

Track Quietly & Trend Loudly



MUST DO #3
Drive Drift Down

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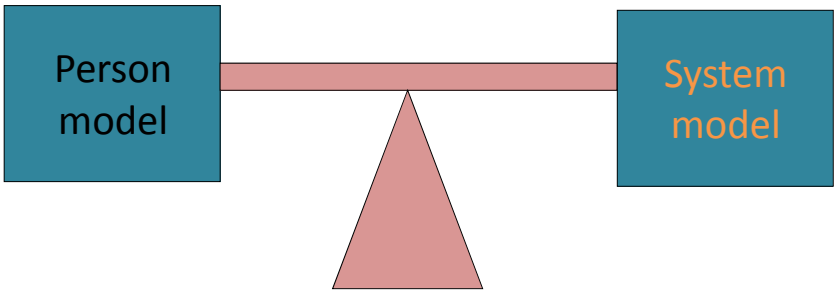
The Right Balance



Important to get the balance right.
Both extremes have their pitfalls.

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Shared Accountability

Instructions:
- Do not share with anyone that you are conducting the audit
- Observe all staff-nurses, physicians, RT's, housekeeping staff, etc. (see other side of form for Staff Codes)
- Observe for 30 minutes. This may be broken up in small increments of time. OR,
- Observe at least 15 staff members

Unit/Department _____ **Date** _____ **Time** _____

Indicate below what activity was observed and check the one box that applies to that activity

PERSON ENTERED THE ROOM FOR DIRECT CONTACT WITH THE PATIENT OR ENVIRONMENT	HAND HYGIENE SUPPLIES (SOAP, HAND SANITIZER, TOWELS) ARE ADEQUATE		DID YOU SEE HIM/HER USE SOAP OR ALCOHOL GEL WHEN ENTERING THE ROOM?		PERSON EXITED THE ROOM AFTER DIRECT CONTACT WITH THE PATIENT OR ENVIRONMENT	DID YOU SEE HIM/HER USE SOAP OR ALCOHOL GEL WHEN EXITING THE ROOM?		PERSON EXITED THE ROOM WITH GLOVES ON AFTER DIRECT CONTACT WITH THE PATIENT OR ENVIRONMENT	DID YOU SEE HIM/HER USE SOAP OR ALCOHOL GEL AFTER REMOVING GLOVES?	
Enter Staff Code	Yes	No	Yes	No	Enter Staff Code	Yes	No	Enter Staff Code	Yes	No
1.										
2.										
3.										
4.										
5.										
6.										
7.										
8.										
9.										
10.										
11.										
12.										
13.										
14.										
15.										
Total # of Staff Observed	Total		Total	Total	Total # of Staff Observed	Total	Total	Total # of Staff Observed	Total	Total

Adapted with permission from Stanford Health Care, Palo Alto, CA

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What works?

- Observation and surveillance of hand hygiene is the best way to ensure appropriate compliance.
- Schedule an unscheduled observation by trained observers.
- Intervene immediately if a breach in HH is observed.
- Provide scripts for reminding peers to perform HH.
- Promote culture of safety .

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CHECK POINT

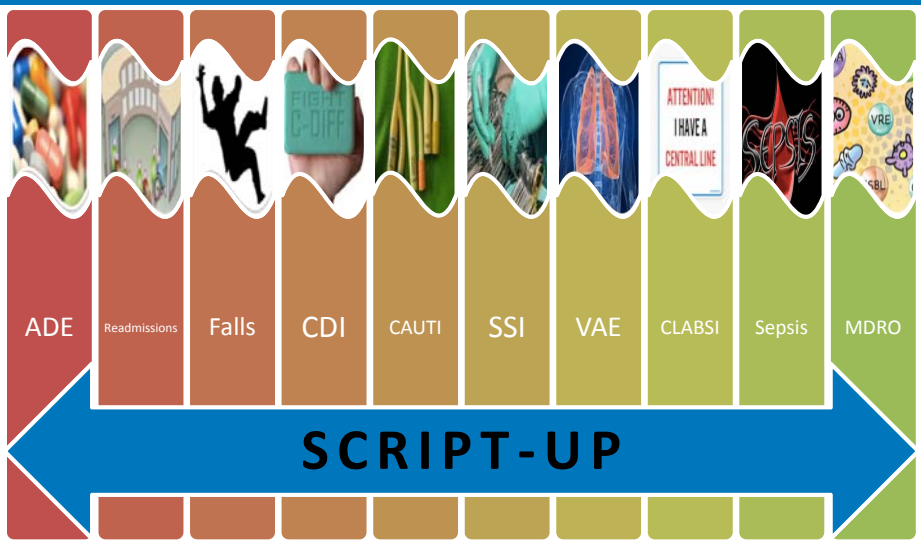
SOAP UP

To reduce: CAUTI, CDI, CLABSI, Sepsis, SSI and VAE and MDRO

- ☐ Are the harms associated with inadequate hand hygiene known?
- ☐ Is there a strong desire to improve hand hygiene?
- ☐ Do you have a hand hygiene policy and procedure?
- ☐ Have staff been educated regarding performance expectations and the policy and procedure specifics?
- ☐ Do you have adequate supplies available to perform hand hygiene?

Why don't people wash their hands?

#4 Optimize Medications



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Why It Matters

- Adverse drug events are the most common cause of harm (AHRQ)
- Overuse and inappropriate use of antibiotics is the key cause of antibiotic resistance (CDC)
- Beers Criteria Medications are linked to poor health outcomes, including confusion, falls, and mortality (Am. Geriatric Society)
- Risk of ADEs almost doubles with ≥ 5 meds (Bourgeois, Shannon et al, 2010)

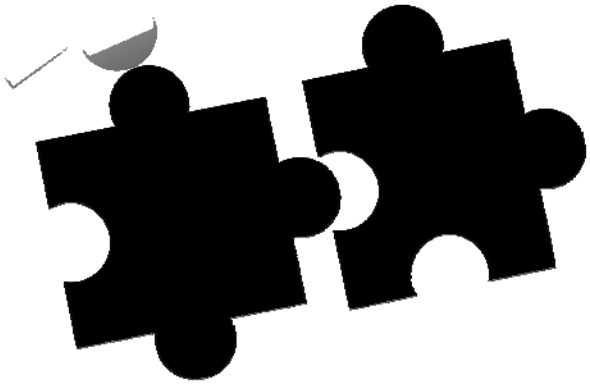
MUST DO's

SCRIPT UP- MUST DO's

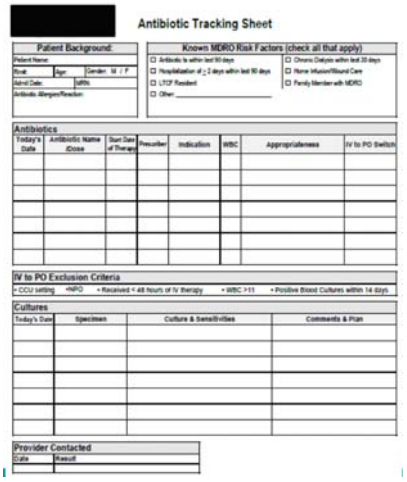
- Match the drug to the bug
- Follow Beers, if they're up in years
- Use appropriate meds -- Less may be more
- Ask if patient needs any medication changes

Must Do #1
Match the Bug to the Drug

- Implement antibiotic time outs at 48 or 72 hours to de-escalate and modify therapy
- Verify the presence of a bacterial or fungal infection



One Idea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Antibiotic Tracking Sheet

Patient Background

Known MDRO Risk Factors (check all that apply)

Antibiotics

Today's Date	Antibiotic Name /Dose	Start Date of Therapy	Prescriber	Indication	WBC	Appropriateness	IV to PO Switch

IV to PO Exclusion Criteria

- CCU setting • NPO • Received < 48 hours of IV therapy • WBC >11 • Positive Blood Cultures within 14 days

Cultures

Today's Date	Specimen	Culture & Sensitivities	Comments & Plan

Provider Contacted

Date	Result

- Pharmacists focus review on patients with a fluoroquinolone order ≥ 48 hours if cultures are back
  - ✓ Review 7-10 patients daily
  - ✓ ~50% require intervention
- Antibiotic monitoring form is completed by pharmacists
- Recommendations made during interdisciplinary rounds or by phone call

NCD Pacing Event 2/9/2017

Getting Started

- Decide what antibiotic to target by considering:
  - Potential risk
  - Volume used
  - High cost
- Set up a review process
- Monitor your results
- Spread to other antibiotics when you can

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Must Do #2: Follow Beers, if they're up in years

- Flag, stop and replace medications on the Beers list
- If needed, switch to a safer agent
- If not needed, discontinue medication

- Anticholinergics
- Antispasmodic agents
- Sleep aids
- Benzodiazepines
- NSAIDS
- Cardiac drugs

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Medications to Avoid in those over 65yrs

Anticholinergics	Benadryl®, Phenergan®, Vistaril®
Antispasmodic agents	Donnatal®, Bentyl®, Librax®, Probanthine®
Sleep aids	Ambien®, Luminal®, Dalmane®, Nembutal®
Benzodiazepines	Ativan®, Valium®, Xanax®, Librium®, Klonopin®
NSAIDS	Advil®, Motrin®, Aleve®
Cardiac drugs	Digoxin > 0.125mg/day, Procardia®, Catapres®

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Provide Alternatives

Drug Class	Preferred Alternative	Special dosing considerations for the elderly

Benzodiazepines	- For insomnia:
	  - emphasize sleep hygiene
	  - treat for underlying disrupters
	  - evaluate timing of other medications and alcohol
	- For chronic anxiety:
	  - consider buspirone or SSRIs or SNIRs
	  - consider psych referral
		- Risk of fall doubled if used more than 14 days

Opioid analgesics		Avoid meperidine

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Provide Alternatives

Drug Class	Preferred Alternative	Special dosing considerations for the elderly
Cardiovascular agents	- For HTN alone - ACE inhibitors, betablockers, or calcium channel blockers preferred	Most significant risk is orthostatic hypotension Monitor closely and educate patient Slowly increase to full dose
Skeletal muscle relaxants		Monitor length of use and discontinue as soon as no longer indicated; recommended for short use only

Help your physicians by providing guidelines about alternatives and any special dosing or monitoring considerations.

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Must Do #3
Use appropriate meds -- less may be more

- Consider shortening med lists, especially PRN medications
  - When adding a med, ask "What can I discontinue?"

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Why less may be better

- There is no set number of medications defining polypharmacy – The CDC uses 6
- Concerns
  - Increased ADE
  - Increased drug interactions
  - Increased costs
  - Prescribing cascade
- Associated with
  - Decreased quality of life, mobility and cognition

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Take Action

- Set a threshold number for review
  - Consider the volume of patients who are at or above the threshold and the amount of pharmacist time that can be dedicated
- Have pharmacist review and consult with physician
- Monitor the impact of your intervention

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Table Top – GET Up Campaign

- Create an Up Campaign Poster for your targeted audience.
  - Nursing Staff, Physical Therapy, Pharmacists, Sr Leadership, Medical Staff, Patients and Families
  - Take 10 minutes to create the Poster
  - Each team presents their campaign to the audience for feedback

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What Will Your Next Steps Be?

Organizing and Leading for High Reliability

Kathy Duncan, Director

September 28, 2017

Objectives

- Summarize the characteristics of an organization on an HRO journey
- Assess where your organization is on the journey to high reliability
- Select one area where you will begin testing new idea(s) from this session
- Discuss how achieving the characteristics of HRO support your aims in the HIIN

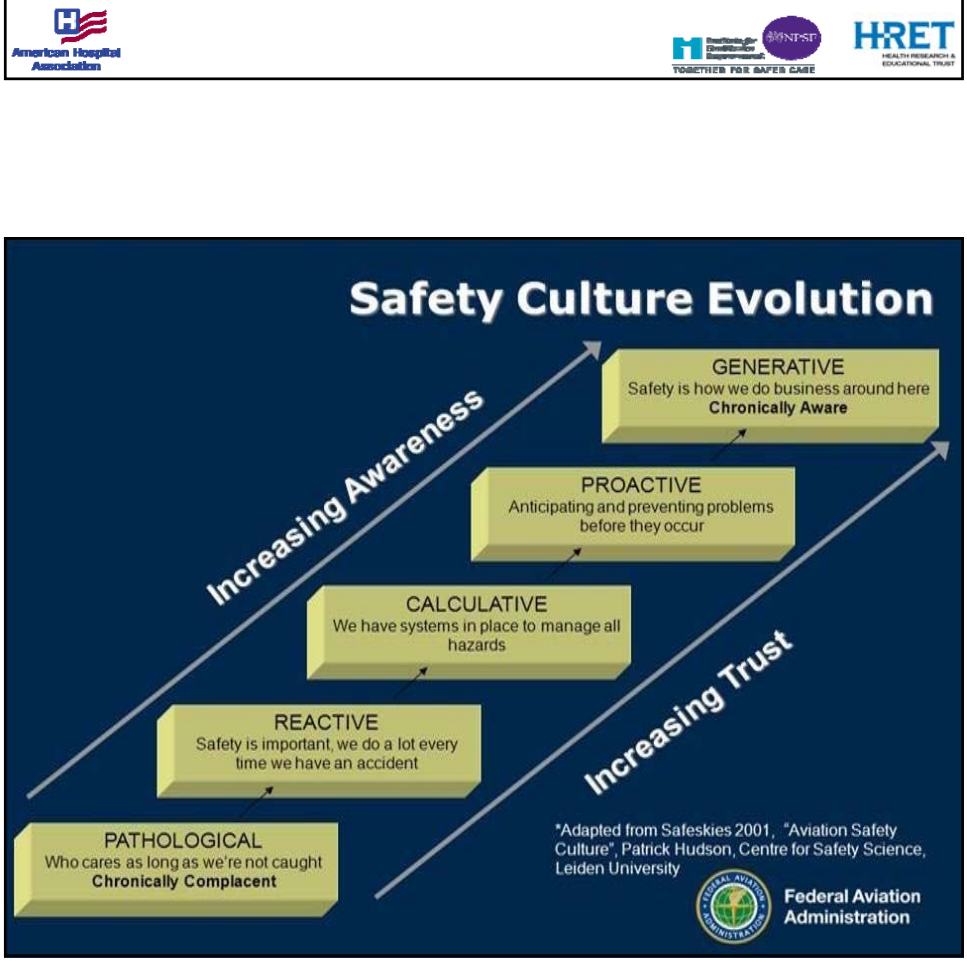
Frank Federico
Institute for Healthcare Improvement
Vice President/Senior Safety Expert

What is safety 2.0?

- An evolution in the way we think about safety
- Safety as a system property
- Focus on building resilience
- Co-design with patients for patients
- Changing the definition to a positive experience for patients (not the lack of a bad experience)
- Safety includes not only preventing known harms, includes proactive search for risk
- Systems to predict and manage deterioration as soon as possible

What does being a high reliability organization (HRO) mean to you?

How will you attain the characteristics of an HRO?



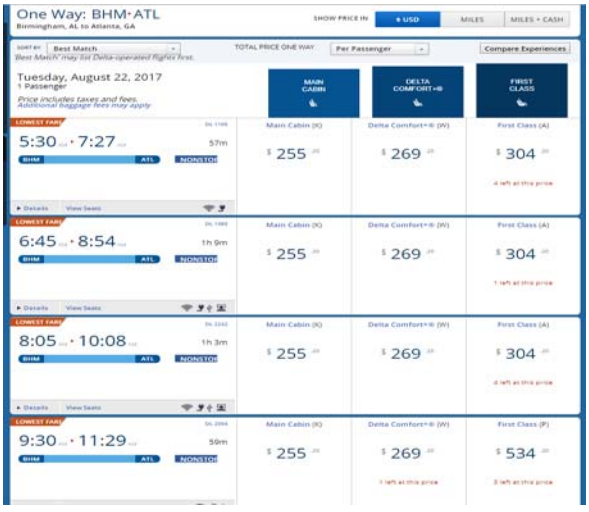
Moving from

Manage the expected to managing the unexpected

High Reliability Organizations

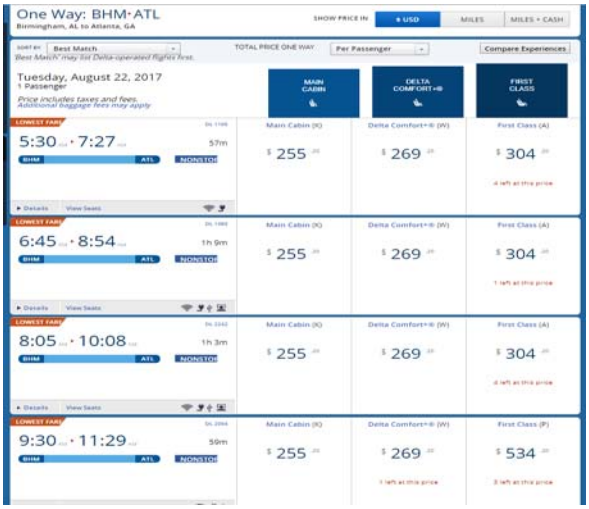
- …rarely fail even though they encounter numerous unexpected events
- …face an "excess" of unexpected events because
  - technologies are complex
  - constituencies vary in demand
  - people who run the systems have incomplete understanding

Expected Conditions



- What are the expected conditions for this schedule?
- What assumptions are made?

What is unexpected?



- What conditions or events are <u>unexpected</u> in the design of this schedule?
- How does an airline <u>identify and respond</u> to these unexpected situations?

The Unexpected

- A person or unit has an intention, takes action, misunderstands the world.
- Actual events fail to coincide with the intended sequence.

From "Managing the Unexpected" by Weick & Sutcliffe

Characteristics of HROs

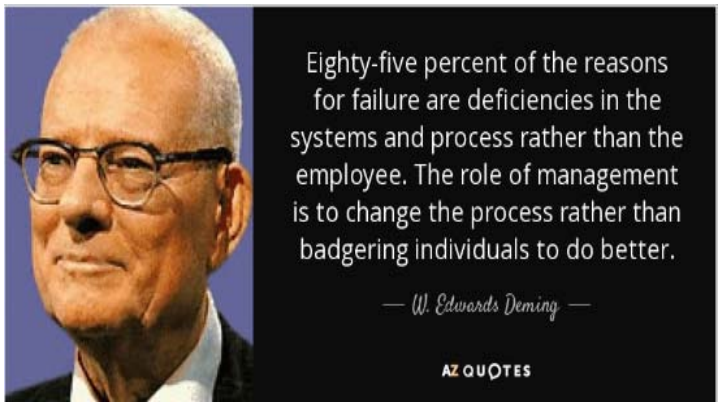
- Pre-occupation with failure
- Reluctance to simplify interpretations
- Sensitivity to operations
- Commitment to resilience
- Deference to expertise

From "Managing the Unexpected" by Weick & Sutcliffe

Saunders Medical Center (CAH)

- 1137+ days without a CAUTI
- 295 + days without a fall with injury

- Cindy Walsh



Group Exercise Regarding CAUTI Prevention

- What steps in the process should be standardized?
- What are the expected conditions?
- What unexpected events or conditions often occur? How is the unexpected recognized?
- What is the response to the unexpected?

Assessing where your organization is on the journey

Self-Assessment

Reactive	Proactive: Managing the Expected	Generative: Managing the Unexpected
Most or all adjustments in patient care (e.g., medication dosing, ventilator weaning, urinary catheter removal) are by physician order.	Standardized approaches are in use for some care processes, such as: standard order sets and standing orders, care pathways, etc.. A few clinical protocols driven by non-physician staff may be in place.	Clinical protocols for patient care adjustments by qualified clinical professionals (NP,RN,RPh,RT,PT, etc.) are common throughout the organization and well supported by medical staff.
Team huddles are rare or occur on an ad hoc basis, typically led by a manager or supervisor.	Huddles are held for some high-risk procedures or situations. Structure is informal with limited tools for standard approach. Focus is on prevention or to debrief event or situation that did not occur according to plan or with adverse outcome.	Structured huddles are held routinely in identified areas and for specific procedures using standard methods and tools. Post-huddles are conducted even when all goes as planned. Huddles are led by team members with expectation for all to speak up.
Few standard care processes are used outside of emergency situations, such as standing orders for cardiopulmonary arrest or in critical care.	Standard care processes have been developed and implemented for critical processes. Clinicians select whether standard processes are used for their patients and sometimes have their own (i.e., standing order sets or kits designed by or for individual clinician).	Content of standardized clinical processes is based on and includes only items well supported by clinical evidence. Systems knowledge and human factors concepts are used to design operational aspects. Clinicians may opt patients out of the standard and all such occurrences are studied to determine whether true exception or redesign needed. Standard is changed when supported by evidence and there is consensus.
Design of new processes is handled by managers. Redesign of current processes rarely happens or happens in response to an event or situation and is handled by managers.	Design of new processes and redesign of current processes includes front line staff in design work. Critical processes are assessed for re-design opportunities on a periodic basis.	Design of new processes and redesign of current processes are driven by front line staff and patients and families are included in design work. There is a regular plan for prospective assessment of all critical processes to identify opportunities to improve.

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A COMPREHENSIVE FRAMEWORK FOR PATIENT SAFETY, RELIABILITY AND CLINICAL EXCELLENCE

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TIMETREE FOR SAFER CARE

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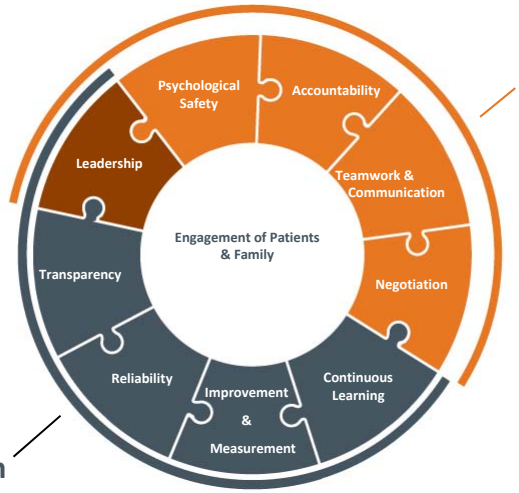
A Reliability Framework

1. Link safety and reliability to organizational strategy and resources
2. Define safety culture
3. Incorporate human factors and reliability science into improvement methods
4. Differentiate types of continuous learning systems (at organization and unit levels)

Framework for Clinical Excellence



Framework for Clinical Excellence

Creating an environment where people feel comfortable and have opportunities to raise concerns or ask questions.

Being held to act in a safe and respectful manner given the training and support to do so.

Facilitating and mentoring teamwork, improvement, respect and psychological safety.

Developing a shared understanding, anticipation of needs and problems, agreed methods to manage these as well as conflict situations

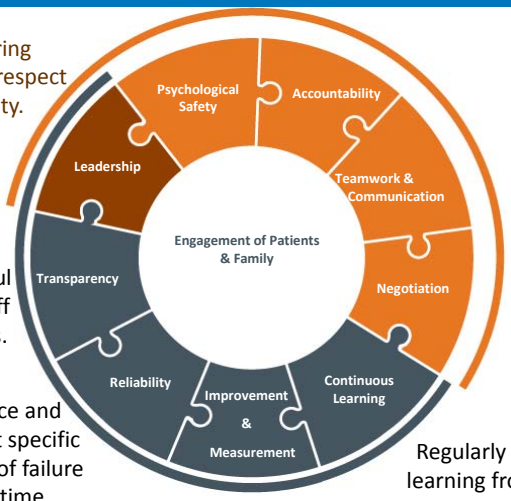
Gaining genuine agreement on matters of importance to team members, patients and families.

Framework for Clinical Excellence

Facilitating and mentoring teamwork, improvement, respect and psychological safety.

Openly sharing data and other information concerning safe, respectful and reliable care with staff and partners and families.

Applying best evidence and minimizing non-patient specific variation with the goal of failure free operation over time.



Improving work processes and patient outcomes using standard improvement tools including measurements over time.

Regularly collecting and learning from defects and successes.

HRO Characteristics[1]	Reliability Under Routine Conditions[2]	IHI Framework for Safe, Reliable and Effective Care Elements
Preoccupation with Failure	Leaders and teams are preoccupied with the reliability of their processes. Default - there are no good processes in place, or organizations have processes in place but they are not reliable, therefore they must be continually improved	Leadership Reliability Improvement & Measurement Continuous Learning Transparency
Reluctance to Simplify Interpretation	Leaders and Teams are reluctant to interpret variation as normal. Processes have become complex resulting in wide variation and results.	Leadership Reliability Continuous Learning Transparency
Sensitivity to Operations	Leaders and Teams know the common failure modes in their routine processes.	Leadership Psychological Safety Accountability Improvement & Measurement Continuous Learning Transparency

1 - Managing the Unexpected: Assuring High Performance in an Age of Complexity. Sutcliffe KE, Weick KM. San Francisco, CA, USA: Jossey-Bass; 2001.

2- Institute for Healthcare Improvement

HRO Characteristics[1]	Reliability Under Routine Conditions[2]	IHI Framework for Safe, Reliable and Effective Care Elements
Commitment and Resilience	Leaders and Teams are committed to timely feedback with data and action to front line about processes and outcomes and commitment at all levels about timely action when sub-optimal performance.	Leadership Psychological Safety Accountability Teamwork and Communication Improvement & Measurement Transparency Continuous Learning
Deference to Expertise	Processes need to be designed by the experts, those with the most relevant training in that area. There expertise if most essential in design not necessarily execution of the process.	Leadership Psychological Safety Teamwork and Communication Continuous Learning Improvement & Measurement

1 - Managing the Unexpected: Assuring High Performance in an Age of Complexity. Sutcliffe KE, Weick KM. San Francisco, California, USA: Jossey-Bass; 2001.

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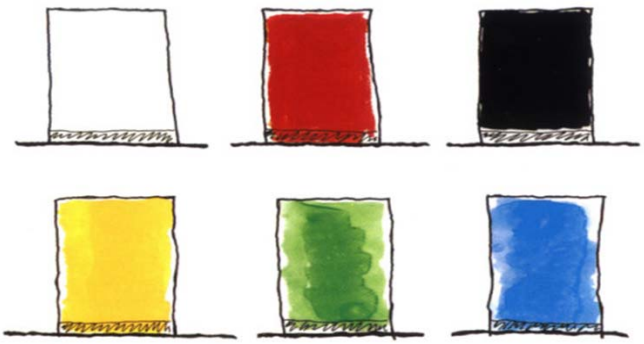

COMING SOON

APPLYING THE FRAMEWORK

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TOGETHER FOR SAFER CARE

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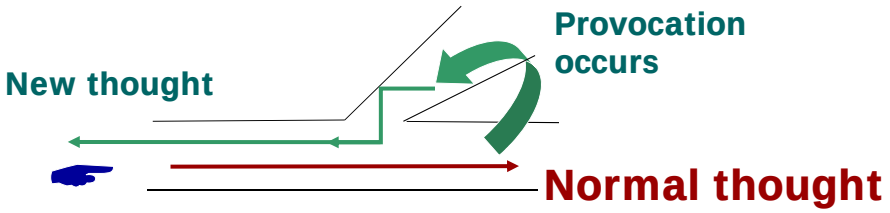
Creative Thinking

- **Creativity implies having thoughts that are outside the normal pattern.**
- **What can you do to have "new" thoughts?**
- **How do we "provoke" new thinking?**

It begins with lateral thinking!



Logical in hindsight

(after that fact everyone is a genius)

The Lateral Thinking of Edward de Bono

“Provocation has everything to do with experiments in the mind.”

Edward de Bono

What might be a Provocation?

“Something to make you think differently”

Benefits of Six Hats for Improvement

- **Explore change concepts and ideas more thoroughly and quickly**
- **Critique and strengthen ideas for change**
- **Shortens meetings and increases participation**
- **Supports constructive and creative thinking**
- **Enables best use of information and team**
- **Harness big egos**

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Six Thinking Hats® of de Bono

A framework for thinking: A method to facilitate team thinking when used to create new ideas or evaluate existing ideas

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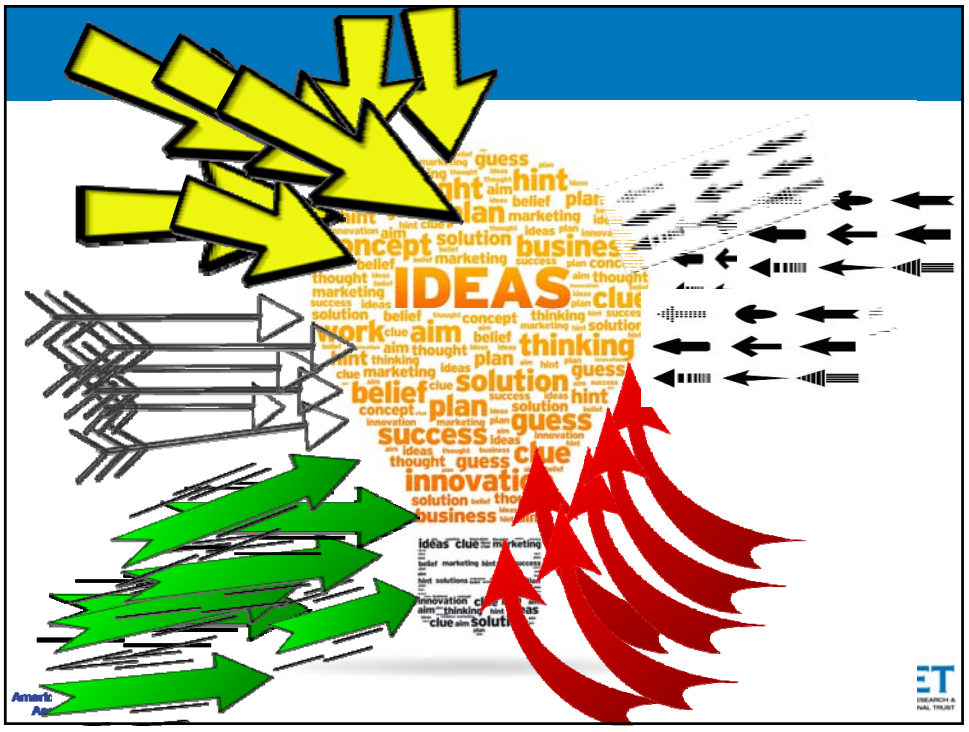
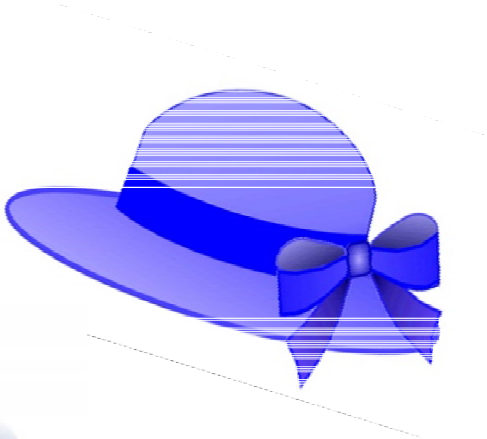
Exercise With the Six Thinking Hats

1. Each participant/group use the thinking hats on a problem/issue/focus area
2. Think with the same hat at the same time
3. Use short bursts of thinking (1-3 minutes)
4. Contribute honestly and fully for each of the hats
5. Record information during each hat - when prompted chat in some thoughts
6. View thinking as a skill – a serious game



Blue Hat



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Blue Hat Thinking

- Control of the thinking process
- Organize the thinking
- Setting the focus and agenda
- Summarize & conclude
- Ensure the rules are followed

Green Hat

Yellow Hat

White Hat

- Information & data
- Neutral & objective
- Source missing information
- Checked & believed facts

Red Hat

- Feelings & intuition
- Emotion or hunches
- No reasons or justification
- Keep it short

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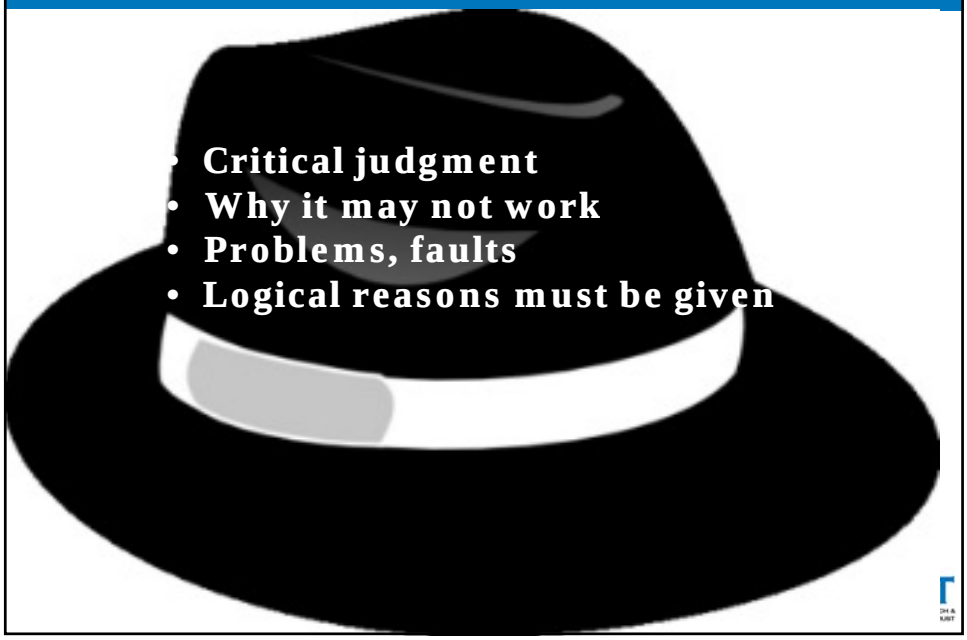
Black Hat



- Critical judgment
- Why it may not work
- Problems, faults
- Logical reasons must be given

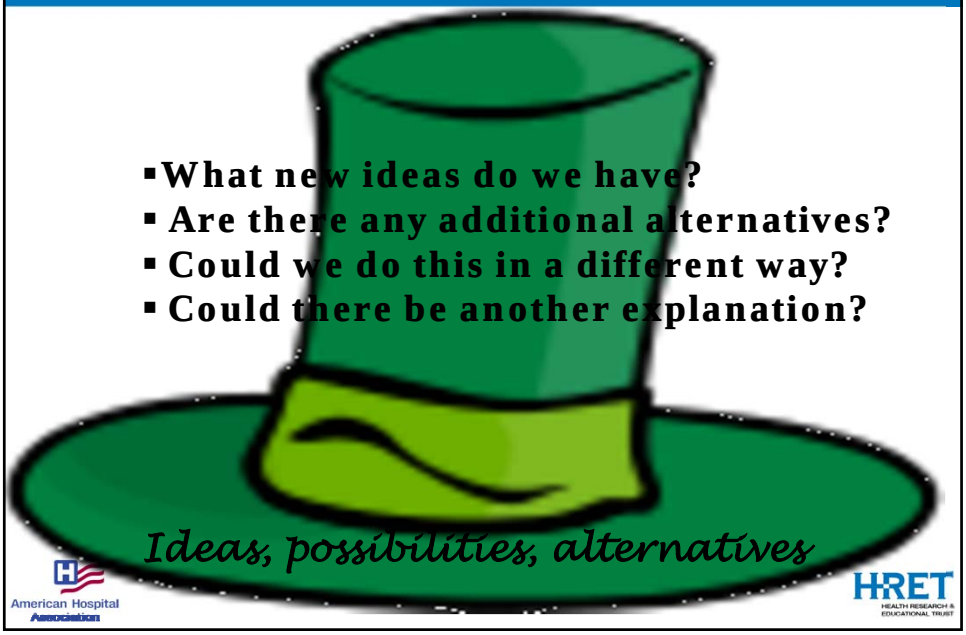
Here's a Provocation for Us……Saint Francis Memorial

- *Implemented a patient and family advisory council and has started a program to assist with mobility for their Parkinson's disease patients. This was identified as a need in the community.*

Focus for today:

Placing a patient on each improvement project team in your organization

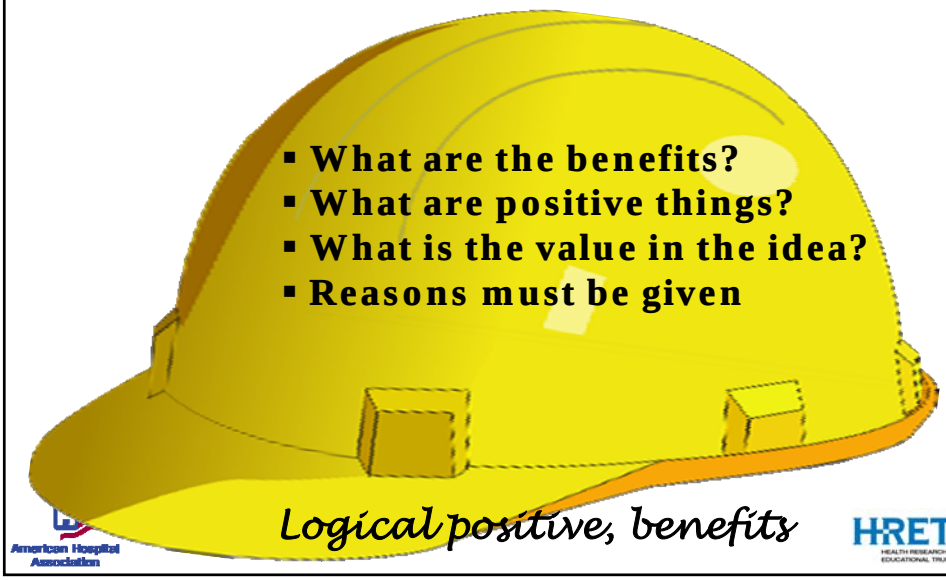
Green Hat Thinking



- What new ideas do we have?
- Are there any additional alternatives?
- Could we do this in a different way?
- Could there be another explanation?

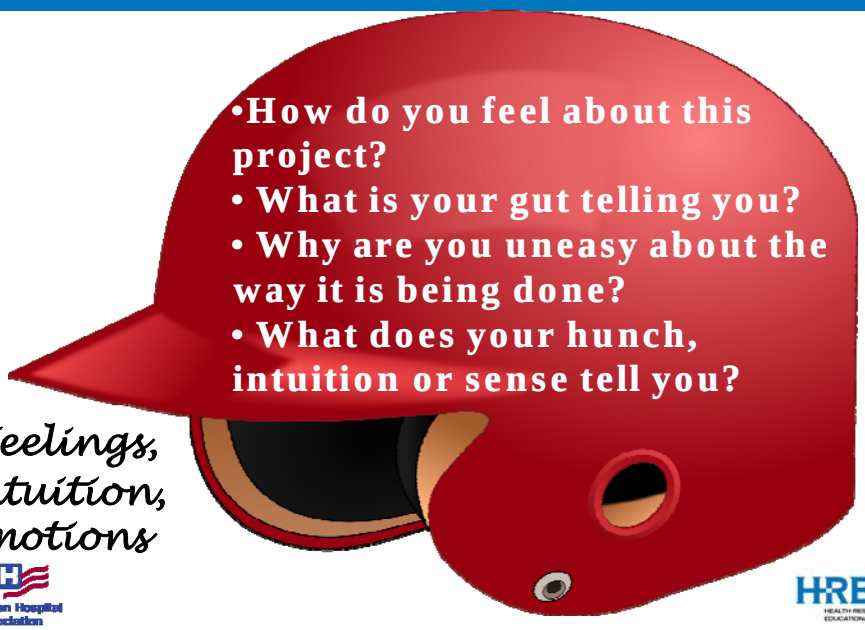
Ideas, possibilities, alternatives

Yellow Hat Thinking



White Hat Thinking

Red Hat Thinking



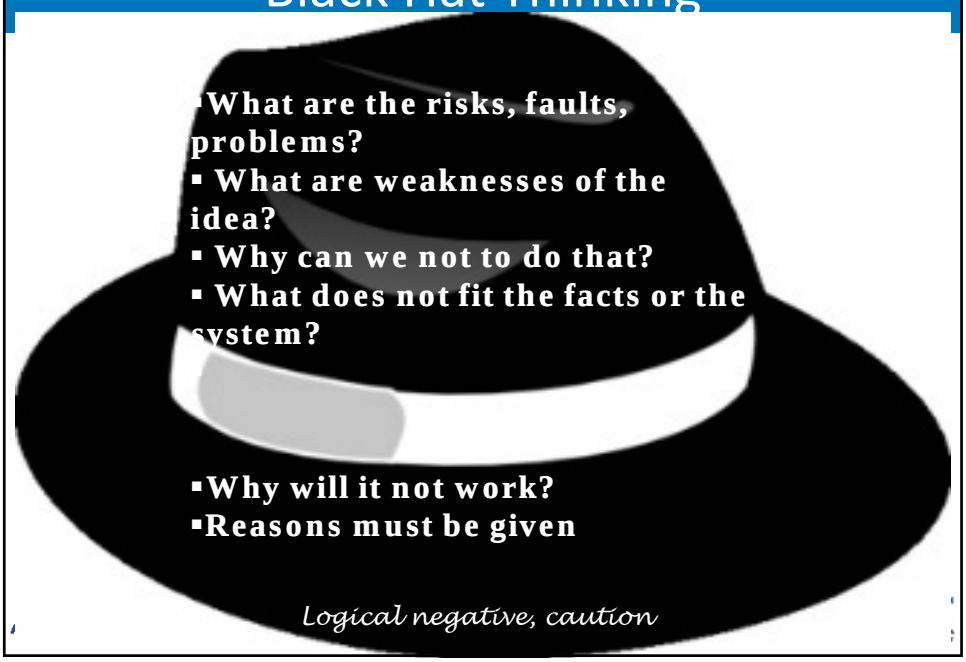
- How do you feel about this project?
- What is your gut telling you?
- Why are you uneasy about the way it is being done?
- What does your hunch, intuition or sense tell you?

Feelings, intuition, emotions

American Hospital Association

HRET HEALTH RESEARCH & EDUCATIONAL TRUST

Black Hat Thinking



- What are the risks, faults, problems?
- What are weaknesses of the idea?
- Why can we not to do that?
- What does not fit the facts or the system?
- Why will it not work?
- Reasons must be given

Logical negative, caution

Your Experience

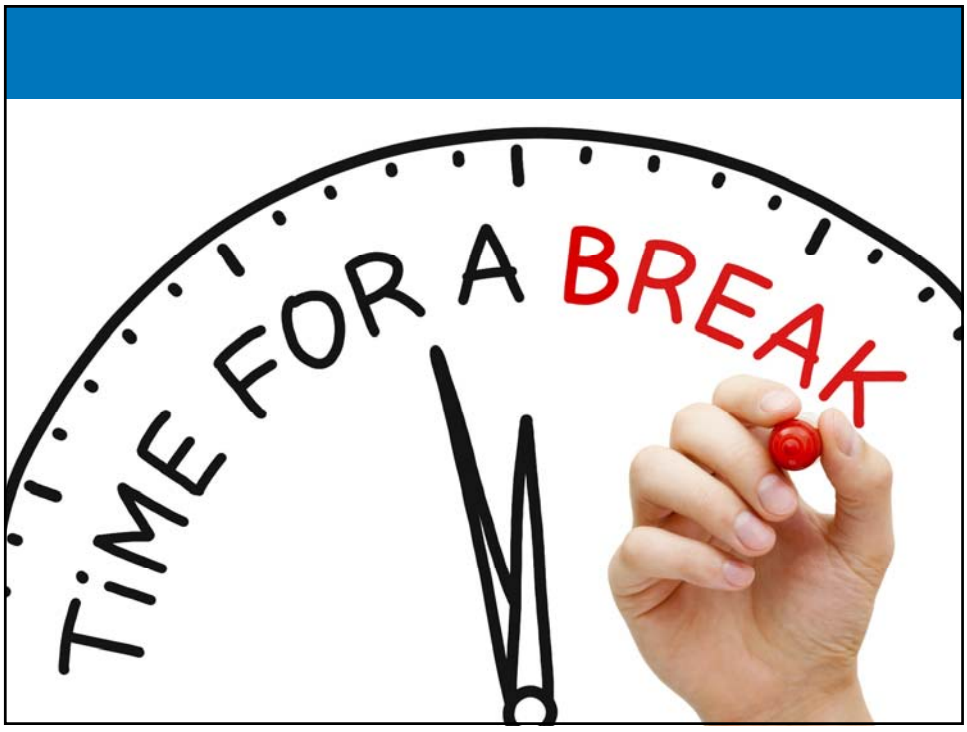
- Did you get any useful ideas for your project during our brief exercise?
- What are your observations/thoughts about using this method within your own organization?

How will you use this?

- Who ?
- What is your provocation?
- What are you observations/thoughts about using this method within your own organization?
- What did you experience as the advantage of wearing one hat at a time – with everyone?

Fillmore County Hospital (CAH)

- Implemented a Nursing Quality Committee to address all areas of harm in the facility.
- Leadership recognized the importance of having front line involved in quality and helping to drive improvements, so the nursing quality committee is now scheduled and paid time for the employees.
- Shari Michl



Moving to High Reliability

- Define the expected conditions
- Set standard(s) for consistency within expected conditions
- Learn from variation to identify recurring unexpected conditions
- Design standard response to common unexpected conditions
- Support mindfulness
  - Identification of unexpected conditions
  - Real time solutions
- Continuous learning and adjustment

Key Categories

- Design
  - Standardization, Input, Human Factors
- Analysis
  - Failures and Successes
  - Data, Feedback
- Redesign
  - Continuous, based on learning from operational adjustments
- Response
  - Proactive vs. Reactive
  - Standard for recurring unexpected conditions

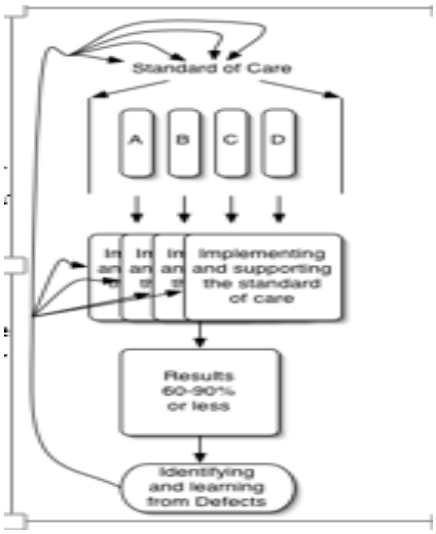
How will you know?

- Process Reliability:
  - If you ask each person how they do it, are there differences in how they describe the process?
  - If the step fails, is how people respond different?

Healthcare processes

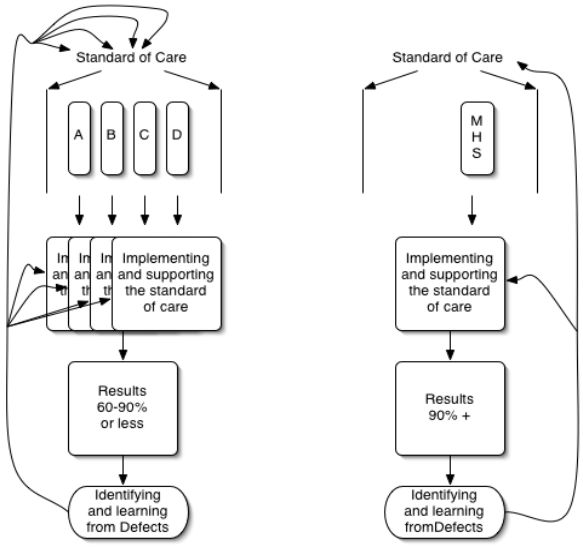
Unreliable

- Lots of autonomy
- Not owned
- Little or no feedback for improvement
- Constantly altered by individual changes
- Performance stable at low levels
- Variable



From Terry Borman, MD, Mayo Health System

Healthcare Processes



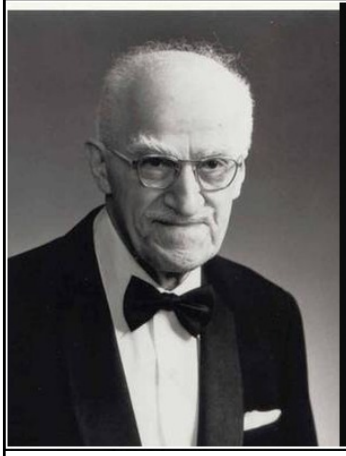
Towards Reliability

- No individual autonomy to change process
- Process owned from start to finish
- Learn from defects before harm occurs
- Constantly improved by collective wisdom
- Variation based on clinical criteria

From Terry Borman, MD, Mayo Health System

Examples of Standardized Approaches

- Checklists (remove reliance on memory)
- Standard kits/carts/supplies
- Daily or every shift review of invasive devices
  - Adjust sensibly– e.g., urinary catheters in ED
- Protocols
  - Dosing by pharmacists
  - Removal of devices by nurses
  - Ventilator weaning by respiratory therapists



Without a standard there is no logical basis for making a decision or taking action.

— Joseph M. Juran —

AZ QUOTES

Workarounds: Good or Bad?

- Good: Signal of unexpected condition
  - Use for learning
  - Design response or redesign as expected
  - Reward staff who identify
- Bad: deliberate variance from standard without unexpected condition

Readiness

- Expected failures
  - Process steps
  - Adverse events, clinical situations
  - Outside events: weather, other organizations
- Do you know what expected failures occur in your organization?
  - If yes, how do you prepare and respond?
- Unexpected failures
  - What have you never prepared for?

What is the role of an expediter?

Managers in an HRO

…take pride in the fact that they spend their time *putting out fires*…as evidence that they are resilient and able to contain the unexpected

What is safety 2.0?

- An evolution in the way we think about safety
- Safety as a system property
- Focus on building resilience
- Co-design with patients for patients
- Changing the definition to a positive experience for patients (not the lack of a bad experience)
- Safety includes not only preventing known harms, includes proactive search for risk
- Systems to predict and manage deterioration as soon as possible

Safety 1 to Safety 2

Safety 1
manifestations of safety
are the adverse outcomes

Safety 2
ability of a system to sustain required operations under both expected and unexpected conditions

Hollnagel E., Wears R.L. and Braithwaite J. From Safety-I to Safety-II: A White Paper. The Resilient Health Care Net: Published simultaneously by the University of Southern Denmark, University of Florida, USA, and Macquarie University, Australia.

Moving from Safety 1 to Safety 2

	Safety 1	Safety 2
Definition	Few things as possible go wrong	
Management principle	Reactive respond to risk	
Human factors	Humans add risk	
Accident investigation	Identify cause	
Risk assessment	Failure effect mode	

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Management principle	Reactive respond to risk	Proactive and anticipate
Human factors	Humans add risk	Humans are a resource
Accident investigation	Identify cause	Understand what goes right to learn what can go wrong
Risk assessment	Failure effect mode	Understand conditions where variability cannot be controlled

Hollnagel E., Wears R.L. and Braithwaite J. From Safety-I to Safety-II: A White Paper. The Resilient Health Care Net: Published simultaneously by the University of Southern Denmark, University of Florida, USA, and Macquarie University, Australia.

Am I in a learning organization?

- Are my employees and managers learning from our work <u>every day</u>?
- Are staff encouraged to identify the need to modify a process and share for learning?
- How often do staff adjust a process based on changing conditions?
- How often do I ask "why", or encourage others to do so?
- How do we find external ideas in my organization?
- When is the last time a front line person suggested an idea that we tried?

Getting Started

- Take advantage of existing groundwork
  - Standard tools, response systems, etc.
- Plan for success: pick a topic and location with receptiveness to change and a champion
  1. Design process: standardize, include front line
  2. Identify the expected conditions for the standard
  3. Identify the recurring unexpected conditions (including human factors) and design response(s)

Starting the journey towards high reliability

- Recognize that you cannot change the culture BUT you *can* change things that will change the culture
- Become a learning organization
  - This has no end point!
- Move to reliable processes and responses first
  - Understand what is expected
  - Prepare to more pro-active, less reactive
- Recognize it is a journey

Thank You!

Questions?

Contact Information

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