Achieving Excellence Through Teamwork
Mainstreaming Quality Improvement
Quality Insights a Learning and Action Network (LAN)

- Five-year contract with the Centers for Medicare & Medicaid Services (CMS)

- Engage hospitals (acute, psychiatric, critical access), ambulatory surgery centers, physician office practices, and nursing homes

- Focus on quality improvement initiatives driven by CMS National Quality Strategy

- Coordinate with strategic partners (Office of Public Health, State Hospital Associations, and Healthcare Engagement Network)
  - Louisiana Primary Care Association
  - Louisiana Rural Health Association
11th Scope of Work Goals

Aims

Foundational Principles

- Enable innovation
- Foster learning organizations
- Eliminate disparities
- Strengthen infrastructure and data systems

Make care safer
Strengthen person and family engagement
Promote effective communication and coordination of care
Promote effective prevention and treatment
Promote best practices
Make care affordable
Presentation Goals

• Leave with one or more ideas you will implement on return to work to enhance culture, promote teamwork, and achieve ongoing performance improvement

• Meet with your team on return to work and develop performance improvement goals addressing your strategic plan and quality improvement needs (including targets, measures, and monitoring and reporting processes)

• Feel comfortable applying the “PDSA” method, and basic performance improvement tools
Presentation Goals
Help You Create The Culture of Geese in Your Workforce

• Always faithful
• Protect what is valuable
• Gifted navigators
• Effective communicators
• Work as a group
• FLY EFFICIENTLY!!
Creating a Culture that Promotes Employee Engagement and Teamwork Starts with the Leaders
The Current Status of Employee Engagement in Healthcare

Advisory Board Company National Engagement Survey
The Importance of Employee Engagement

• Gallup defines engaged employees as “psychologically committed to their job and likely to be making positive contributions to their organizations.”

• Gallup says actively disengaged workers cost employers $292 billion to $355 billion a year.

• According to Gallup, the number one factor influencing engagement and disengagement was the employees' relationship with their immediate supervisors (leaders).

The Leader’s Influence on Culture
(15 Traits of a Terrible Leader)

• Lack of transparency and honesty
• Not listening
• Dismissing Ideas Other than Your Own
• Valuing Experience Over Potential
• Ego

www.success.com/Article/15-traits-of-a-terrible-leader (Interviews with members of the Young Entrepreneur Council – YEC)
The Leader’s Influence on Culture
(15 Traits of a Terrible Leader)

• Working 24/7
• Lack of empathy
• Forgetting about leadership development
• Being overly conservative
• Permitting negative gossip

www.success.com/Article/15-traits-of-a-terrible-leader (Interviews with members of the Young Entrepreneur Council – YEC)
The Leader’s Influence on Culture
(15 Traits of a Terrible Leader)

• Poor communication of strategy
• Closed-mindedness
• Assigning blame
• Inconsistency
• Being too slow to adapt

www.success.com/Article/15-traits-of-a-terrible-leader (Interviews with members of the Young Entrepreneur Council – YEC)
Creating Successful Teams
(Be Honest and Transparent)

• Staff know if you are not being honest

• Share as much information as you are allowed, the team needs to know where the organization stands

• Allows for team to focus on problems that need to be solved for long-term benefits

-Mitch Gordon, Go Overseas
Creating Successful Teams
(Listen)

• Listen to ALL as OFTEN as possible

• Everyone needs to be part of the process and bigger picture

• Builds loyal and faithful team

-Jason Grill, Media
Creating Successful Teams
(Use the Ideas of Others)

• Don’t think you are the only one on your Team capable of spinning gold

• Listen to good ideas and help develop them

• Provide strong praise and credit where it is due

-Jeff McGregor, Dash
Creating Successful Teams
(See the Potential in Others)

• Some of the best employees are not the most experienced

• Look for attributes, such as a fire in the belly, which are impossible to train or develop

• Look for employees committed to delivering world-class care

-Chris Cancialosi, Gotham Culture
Creating Successful Teams
(Practice Humility)

• Accept the blame when things go wrong

• Give credit to the team when things go right

• Focus on “your people”, because without them you would be nowhere

~Nick Friedman, College Hunks Hauling Junk
Creating Successful Teams
(Achieve Balance)

• Don’t work all the time, have other interests and learn how to take a break

• Others will assume they must work as much as you do and this creates burnout of the entire team

• Burnout creates a toxic culture

-Susan LaMotte, Exaqueo
Creating Successful Teams
(Be Empathetic)

- Understand the problems team members face
- Remove as many barriers as possible to enable the team to do its work
- Usual barriers are lack of resources, lack of direction, and a lack of culture

-Adam Root, Hiplogiq
Creating Successful Teams
(Develop New Leaders)

• Educate and create a growth plan for your employees

• Increases retention and makes for a “smarter and hungrier” team

• Your team must NOT fail to learn and grow, things are always changing

-Sujan Patel, When I Work
Creating Successful Teams
(Prohibit Negative Gossip)

• Spreading negative gossip isolates the recipient

• Negative gossip shatters trust and establishes a culture of fear and back-stabbing

• Tolerating gossip leads to loss of morale and impedes the flow of honest feedback and communication throughout the workplace

-David Hassell, 15 Five
Creating Successful Teams
(Communicate Strategy Effectively)

• Staff need to know not only where the organization is going, but also factors that were considered in developing the strategy

• Staff should not be expected to follow blindly

• Don’t just work out ideas and plans in your head, write them down to make sure that processes and conclusions are easy to understand

-Benish Shad, Before the Label
Creating Successful Teams
(Don’t Play the Blame Game)

• Take responsibility for team failures and look at them with the team as an opportunity to learn and grow

• Propose solutions rather than assigning blame

• Don’t LISTEN to others when they try to “play the blame game”

• Never throw ANYONE under the bus

-Lane Campbell, Syntress SCDT
Creating Successful Teams
(Adapt Quickly)

• Keeping up with change is CRITICAL

• Lack of knowledge leads to indecision and fear

• Failure to adapt leads to loss of trust

-Neil Thanedor, LabDoor
Best Practices in Employee Engagement – A Few Additional Thoughts
Creating the Workplace Culture
– Make Great Hires

• An employee will be at their best on the day(s) they interview for a job

• Never hire out of desperation

• Include current employees in the selection process

• Always check references and validate skills
Creating the Workplace Culture
- Start Engagement Activities Early

• Engagement should begin on day one

• Provide training (orientation) and set goals before the first day on the job to create a sense of expectation

• Implement mentor programs as a parallel program to orientation to quickly break down social barriers (clicks) and welcome new employees into the work family

• Introduce new employees to the team as part of the hiring process

Source: Cornerstone on Demand, The Challenging State of Employee Engagement in Healthcare Today – and Strategies to Improve It
Creating the Workplace Culture

- Create Career Paths

• In addition to being a key driver of employee engagement, succession planning is critical for organizational longevity

• Employees with access to career planning development opportunities are less likely to leave the organization

• Levels of employee satisfaction, engagement, and commitment increase with organizational succession planning

Source: Cornerstone on Demand, The Challenging State of Employee Engagement in Healthcare Today – and Strategies to Improve It
Creating the Workplace Culture
-Make Learning/Development a Priority

- Organizations with “meaningful learning and development opportunities” have the most engaged workforce, lower turnover rates and increased productivity

- Ongoing learning opportunities improve performance and improve employee confidence

- A commitment to “on-demand training” results in better patient care and improved patient safety and compliance

- Educate front-line supervisors about early engagement and satisfaction of employees... “employees leave supervisors, not employers”

Source: Cornerstone on Demand, The Challenging State of Employee Engagement in Healthcare Today – and Strategies to Improve It
Best Practices for Staff Development

Paul Hersey and Ken Blanchard, Situational Development Theory
Creating the Workplace Culture
- Provide Opportunities for Recognition

• Recognition programs lead to increased employee productivity, employee engagement, and lower turnover rates

• Recognition is critical for nurses and other “on-the-floor” staff

• Recognition programs need to be ongoing, not just an annual event

• A culture of recognition should be created

Source: Cornerstone on Demand, The Challenging State of Employee Engagement in Healthcare Today – and Strategies to Improve It
Creating the Workplace Culture
- Align Employee Goals with Organizational Goals

• Most healthcare workers are motivated by the need to serve

• Employee loyalty is kindled when organizational leaders exhibit a passion to serve by setting measurable and actionable goals for quality of care, safety, and service excellence

• Healthcare organizations need to integrate employee passion and organizational goals with learning and development opportunities

• Ongoing performance evaluations and learning should be linked to relevant organizational goals

Source: Cornerstone on Demand, The Challenging State of Employee Engagement in Healthcare Today – and Strategies to Improve It
Creating the Workplace Culture
- Working in Healthcare is Difficult but Rewarding

• Working in healthcare is not a job, it is a calling

• The organization MUST provide the support front line staff need in order to provide high quality, safe, and efficient care

• There is no such thing as, “that is not my job”.

“We should consider it a privilege to care for people at one of the most vulnerable points in their lives.”

- James E. Cathey, Jr., CEO, North Oaks Health System
Strategic Goals for Ongoing Quality Improvement in Healthcare

Determining What is Mission Critical
• **This is the inaugural report** of the American Hospital Association Committee on Performance Improvement.

• Report identifies must-do, priority strategies and core organizational competencies organizations should establish to remain successful.
AHA’s Hospitals and Care Systems of the Future
Must-Do Strategies for Future Success

• Align hospitals, physicians and other providers across the care continuum

• Use evidence-based practices to improve quality and patient safety

• Improve efficiency through productivity and financial management

• Develop integrated information systems

• Join and grow integrated provider networks and care systems
AHA’s Hospitals and Care Systems of the Future
Must-Do Strategies for Future Success

- Educate and engage employees and physicians to create leaders
- Strengthen finances to facilitate reinvestment and innovation
- Partner with payers
- Advance through scenario-based strategic, financial and operational planning
- Seek population health improvement through pursuit of the “triple aim”
QA/PI Mission Critical Resources

CMS 11th Scope of Work

Aims
- Better Health
- Better Care
- Lower Cost

Goals
- Make care safer
- Strengthen person and family engagement
- Promote effective communication and coordination of care
- Promote effective prevention and treatment
- Promote best practices for healthy living
- Make care affordable

Foundational Principles:
- Enable innovation
- Foster learning organizations
- Eliminate disparities
- Strengthen infrastructure and data systems

Mission critical
MEDICAL ERROR DEFINITION

“An unintended act (either of omission or commission) or one that does not achieve its intended outcome, the failure of a planned action to be completed as intended (an error of execution), the use of a wrong plan to achieve an aim (an error of planning), or a deviation from the process of care that may or may not cause harm to the patient”

-Institute of Medicine
MEDICAL ERRORS THIRD LEADING CAUSE OF DEATH IN U.S.

• John Hopkins Researchers, Martin Makary and Michael Daniel published an article in early May, 2016

• Noted that the Center for Disease Control and Prevention (CDC)’s annual list of the most common causes of death in the United States, is created using ICD codes on death certificates

• Causes of death not associated with an ICD code, such as human and system factors, are not captured

• The authors argue that deadly medical errors, conservatively estimated at over 250,000 annually, should be included in the rankings — which would make medical errors the third leading cause of death in the US, just after heart disease and cancer

BMJ 2016;353:i2139
“Despite the knowledge that hand washing helps prevent healthcare-associated infections, hand hygiene compliance rates range between 25 percent and 51 percent, according to a study published in the American Journal of Infection Control.”
“The CDC estimates that 5 percent of all hospital admissions result in infections that patients acquire during their stay while receiving treatment for other conditions, culminating in 1.7 million infections and 99,000 deaths each year as well as $28-$33 billion in excess costs.”
2013

The CDC Categorized *Clostridium Difficile Infection* as an Immediate Public Health Threat Requiring Urgent and Aggressive Action

CDC- Louisiana Statistics for Healthcare Associated Infections

LOUISIANA ACUTE CARE HOSPITALS

Healthcare-associated infections (HAIs) are infections patients can get while receiving medical treatment in a healthcare facility. Working toward the elimination of HAIs is a CDC priority. The standardized infection ratio (SIR) is a summary statistic that can be used to track HAI prevention progress over time; lower SIRs are better. The infection data are reported to CDC’s National Healthcare Safety Network (NHSN). HAI data for nearly all U.S. hospitals are published on the Hospital Compare website. This report is based on 2014 data, published in 2016.

CLABSI

- 40% LOWER COMPARED TO NATL BASELINE

CENTRAL LINE-ASSOCIATED BLOODSTREAM INFECTIONS

When a tube is placed in a large vein and not put in correctly or kept clean, it can become a way for germs to enter the body and cause deadly infections in the blood.

- Louisiana hospitals reported no significant change in CLABSI between 2013 and 2014.
- Among the 49 hospitals in Louisiana with enough data to calculate an SIR, 17% had an SIR significantly higher (worse) than 0.80, the value of the national SIR.

CAUTI

- 20% LOWER COMPARED TO NATL BASELINE

CATHETER-ASSOCIATED URINARY TRACT INFECTIONS

When a urinary catheter is not put in correctly, not kept clean, or left in a patient for too long, germs can travel through the catheter and infect the bladder and kidneys.

- Louisiana hospitals reported no significant change in CAUTI between 2013 and 2014.
- Among the 67 hospitals in Louisiana with enough data to calculate an SIR, 7% had an SIR significantly higher (worse) than 1.00, the value of the national SIR.

MRSA Bacteremia

- 8% HIGHER COMPARED TO NATL BASELINE

LABORATORY IDENTIFIED HOSPITAL-ONSET BLOODSTREAM INFECTIONS

Methicillin-resistant Staphylococcus aureus (MRSA) is bacteria usually spread by contaminated hands. In a healthcare setting, such as a hospital, MRSA can cause serious bloodstream infections.

- Louisiana hospitals reported no significant change in MRSA bacteremia between 2013 and 2014.
- Among the 39 hospitals in Louisiana with enough data to calculate an SIR, 26% had an SIR significantly higher (worse) than 0.67, the value of the national SIR.

SSIs

SURGICAL SITE INFECTIONS

When germs get into an area where surgery is or was performed, patients can get a surgical site infection. Sometimes these infections involve only the skin. Other SSIs can involve tissues under the skin, organs, or implanted material.

- SSIs: Abdominal Hysterectomy - 25% LOWER COMPARED TO NATL BASELINE
  - Louisiana hospitals reported no significant change in SSIs related to abdominal hysterectomy between 2013 and 2014.
  - Among the 13 hospitals in Louisiana with enough data to calculate an SIR, 8% had an SIR significantly higher (worse) than 0.63, the value of the national SIR.

- SSIs: Colon Surgery - 5% LOWER COMPARED TO NATL BASELINE
  - Louisiana hospitals reported no significant change in SSIs related to colon surgery between 2013 and 2014.
  - Among the 36 hospitals in Louisiana with enough data to calculate an SIR, 3% had an SIR significantly higher (worse) than 0.98, the value of the national SIR.

C. difficile Infections

LABORATORY IDENTIFIED HOSPITAL-ONSET C. difficile INFECTIONS

When a person takes antibiotics, good bacteria that protect against infection are destroyed for several months. During this time, patients can get sick from Clostridium difficile (C. difficile), bacteria that cause potentially deadly diarrhea, which can be spread in healthcare settings.

- Louisiana hospitals reported a significant increase in C. difficile infections between 2013 and 2014.
- Among the 75 hospitals in Louisiana with enough data to calculate an SIR, 1% had an SIR significantly higher (worse) than 0.92, the value of the national SIR.

*Statistically significant
Quality Improvement Opportunities in Patient Safety: Antibiotic Overutilization

Community Antibiotic Prescribing Rates by State (2013/2014)*

50% of all antibiotics prescribed in U.S. health provider offices are either unnecessary or inappropriate

*Antibiotic prescriptions per 1000 persons
Prescribing data from 2014; population data from 2013
Source: IMS Health
Quality Improvement Opportunities in Patient Safety

Each year in the United States, at least 2 million people become infected with bacteria that are resistant to antibiotics and at least 23,000 people die each year as a direct result of these infections.
Quality Improvement Opportunities in Patient Safety

A National Institute of Health study recently found that 40% of seniors aged 65 and older take five or more prescription medications, and 90% take at least one prescription. The same study found that as many of 55% of seniors take their medications incorrectly.

- Take too much medication
- Confuse medications with one another
- Medicines interact with one another
- Food and drug interactions
- Wrong route of administration
Quality Improvement Opportunities in Patient Safety

- **Communication breakdowns** figured in 30 percent of all malpractice claims filed between 2009 and 2013

- 37 percent of all high-severity injury cases (including death) involved a **communication failure**

- 44 percent of **miscommunication** occurred in inpatient settings, 48 percent in ambulatory settings, and 8 percent in emergency departments

- 57 percent of cases reflected **miscommunication between two or more healthcare providers**; 55 percent involved miscommunication between providers and patients; and 12 percent involved breakdowns in both categories

CRICO, 2015 Malpractice Risks In Communications Report
Dr. House and the Asthmatic Patient

Show me how you take your inhaler.

Do I look like an idiot?
Developing the Quality Improvement Program and **Involving Staff**

**MAINSTREAMING QUALITY IMPROVEMENT**
Step One
Establish Performance Improvement Objectives

• Leaders establish organization priorities for quality improvement that align with the strategic plan

• Leaders review current statistics for priority areas compared to national or other benchmarks

• Leaders identify opportunities for immediate action

• Leaders bring opportunities for performance improvement to approval group, if formal process is in place
Step Two
Implement Performance Improvement Objectives

• Leaders meet with employees to set expectations for involvement by all in performance improvement activities (place expectations in job descriptions; develop clinical ladders)

• Leaders review goals and specific opportunities applicable to the facility, department, and/or employees

• Leaders place employees on teams, according to their interests, to address specific opportunities identified, and appoint team leaders

• Leaders provide “just in time” education on quality improvement processes and approaches
• QA/PI Goal #1
  – We will investigate and act on opportunities to improve patient safety in the areas of:
    • Infection Prevention – hand washing
    • Healthcare Associated Infections, including CLABSI, CAUTI, and CDI
    • Antimicrobial Stewardship Programs with a focus on antimicrobial over-utilization and resistance
    • Patient understanding of medications
    • Effective communication to include daily huddles and bedtime shift report
Setting QA/PI Goals with Staff Members

• QA/PI Goal #2
  – We will investigate and act on opportunities to improve financial and clinical efficiency in the areas of:
    • Staff turnover
    • Patient wait times
    • Duplication of work processes for patient assessment and charting
    • Decreasing clutter and ease of finding supplies
    • Readmissions
    • Missed appointments
# Worksheet for Development of Team Project Plan

<table>
<thead>
<tr>
<th>Business Case:</th>
<th>Opportunity Statement:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Why should we do this? Why should we do it now?</td>
<td>What “pain” are we experiencing?</td>
</tr>
<tr>
<td>How does this project align with organization strategies?</td>
<td>What “pain” are our customers and/or suppliers feeling?</td>
</tr>
<tr>
<td>What quantified benefits can be derived from success at this project?</td>
<td>Note: symptoms (“pain”) often help a team to focus on potential root causes and assist in zeroing in on the most relevant issues.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Goal Statement:</th>
<th>Project Scope:</th>
</tr>
</thead>
<tbody>
<tr>
<td>What are the measurable performance targets or goals (including associated variability around those goals)?</td>
<td>What specific process are we addressing?</td>
</tr>
<tr>
<td>What is the current baseline performance (including variability), stated in comparable measurement terms?</td>
<td>Where does the process start and end?</td>
</tr>
<tr>
<td></td>
<td>What business components are included / not included?</td>
</tr>
<tr>
<td><strong>Note:</strong> The difference between current performance and goals define the “gap.”</td>
<td>Is there any part of this process that is considered “out of scope” for our project?</td>
</tr>
<tr>
<td></td>
<td>What, if any, are the resource constraints?</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Project Plan:</th>
<th>Team Selection:</th>
</tr>
</thead>
<tbody>
<tr>
<td>What are the key milestones (e.g., team kickoff, major phase completion dates, presentation dates, etc.)?</td>
<td>Who is the Team Leader?</td>
</tr>
<tr>
<td>In what time frame do we need to deliver these results?</td>
<td>Who is coaching the team (Master Black Belt)?</td>
</tr>
<tr>
<td></td>
<td>Who are the team members?</td>
</tr>
<tr>
<td></td>
<td>What are their skills? What are their responsibilities on the team?</td>
</tr>
<tr>
<td></td>
<td>Who is the project sponsor?</td>
</tr>
<tr>
<td></td>
<td>Who is the process owner?</td>
</tr>
</tbody>
</table>
DMAIC QAPI Process - Writing Goals

Define Your Goal: SMART Goals

- **S** Specific: Your goal should be as specific as possible and answer the questions: What is your goal? How often or how much? Where will it take place?

- **M** Measurable: How will you measure your goal? Measurement will give you specific feedback and hold you accountable.

- **A** Attainable: Goals should push you, but it is important that they are achievable. Are your goals attainable?

- **R** Relevant: Choose goals that matter. Does your goal match your mission statement? Is it consistent with other goals and objectives?

- **T** Timely: Do you have a timeframe listed in your SMART goal? This helps you be accountable and helps in motivation.

Source: [http://www.cod.edu/people/faculty/osulliva/phys1554/WeightMatters/plan.html](http://www.cod.edu/people/faculty/osulliva/phys1554/WeightMatters/plan.html)
First, Go for Some Easy Wins

PROMOTE EFFICIENCY
5S – Decrease Clutter/Improve Workflow

SORT
- Clearly distinguish needed items from unneeded and eliminate the latter

STRAIGHTEN
- Keep needed items in the correct place to allow for easy and immediate retrieval

SUSTAIN
- Maintain established procedures
- The method by which “Sort,” “Straighten” and “Shine” are made habitual

SHINE
- Keep the workplace neat and clean

STANDARDIZE
First, Go for Some Easy Wins

PROMOTE SAFETY

Implement Huddles

https://www.youtube.com/watch?v=dJRORZEiXpo
Quality Improvement Methods, Tools and Case Study
Case Study

During a Patient Safety Committee meeting, the leaders of Misty Hollow Parish Hospital reviewed a Patient Safety dashboard report for the last six months, and noted that the Standardized Infection Ratios (SIRs) for *Clostridium difficile* had tripled.

The Chief Nursing Officer and Chief of Staff were asked to investigate and address the issue. They were directed to improve care with a target of CDI ratios at or better than current national reported within the next twelve months.

CDI Ratio = Actual CDI Events/Expected CDI Events
# Case Study, cont.

<table>
<thead>
<tr>
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</tr>
</thead>
<tbody>
<tr>
<td>Catheter-Associated Urinary Tract Infection (CAUTI) Standardized Infection Ratio (SIR) (rolling 6 months data)</td>
<td>0</td>
<td>1.06</td>
<td>0.95</td>
<td>1.00</td>
<td>1.05</td>
<td>1.12</td>
<td>1.28</td>
<td>1.35</td>
</tr>
<tr>
<td>Central Line-Associated Blood Stream Infection (CLABSI) Standardized Infection Ratio (SIR) (rolling 6 months data)</td>
<td>0</td>
<td>0.54</td>
<td>0.23</td>
<td>0.42</td>
<td>0.32</td>
<td>0.54</td>
<td>0.59</td>
<td>0.84</td>
</tr>
<tr>
<td>Clostridium <em>Difficile</em> Infection (CDI) Standardized Infection Ratio (SIR) (rolling 6 months data)</td>
<td>0</td>
<td>.90</td>
<td>2.28</td>
<td>2.80</td>
<td>2.00</td>
<td>2.06</td>
<td>1.00</td>
<td>0.70</td>
</tr>
</tbody>
</table>
Case Study

The Chief Nursing Officer, Chief of Staff, Infection Preventionist, and Nursing Director of the Medicine Unit met. They used the Centers for Disease Control and Prevention (CDC) website and Quality Insights’ website to identify best practices.

Working together, they prepared a Fishbone diagram of likely potential causes of increased *C. difficile* infection ratios in the hospital.
Case Study, cont.

Increased CDI Ratio

Environment
- Isolation delays
- Room Cleaning
- Antibiotic Overutilization
- Lab testing sensitivity

Equipment/Meds

Method
- Late orders for cultures
- Inappropriate stool specimens
- Poor handwashing
- Physicians Culturing asymptomatic patients
- Patient/Family/Visitor Awareness

People

Increased CDI Ratio
Case Study

The Chief Nursing Officer, Chief of Staff, Infection Preventionist and Nursing Director of the Medicine Unit established the **Team Goal statement**.

“The Team will implement changes to include the consistent application of best practices in *C. difficile* infection prevention in order to achieve a facility-wide Standardized Infection Ratio at or better than the national SIR (currently 0.90) within the next 12 months.”
Case Study

Based on their review of the literature and knowledge of current processes, the Chief Nursing Officer, Chief of Staff, Infection Preventionist and Medicine Unit Director established the scope of the *C. difficile* infection reduction project.

- The scope of the project will include an evaluation of all processes related to *C. difficile* prevention starting with the arrival of the patient in the Emergency Department through discharge
- The scope will include an evaluation of policies and procedures
- The scope will also include education for all appropriate hospital personnel based on identified needs
Case Study

The Chief Nursing Officer, Chief of Staff, Infection Preventionist and Medicine Unit Director recommended Team members.

Recommendations were approved, directors of team members were notified, and initial meeting date was set.
<table>
<thead>
<tr>
<th>Role</th>
<th>Title</th>
</tr>
</thead>
<tbody>
<tr>
<td>Team Champion</td>
<td>Chief Nursing Officer</td>
</tr>
<tr>
<td>Medical Staff Champion</td>
<td>Medical Staff Chief</td>
</tr>
<tr>
<td>Team Facilitator</td>
<td>Quality Improvement Director</td>
</tr>
<tr>
<td>Team Secretary</td>
<td>CNO Administrative Assistant</td>
</tr>
<tr>
<td>Process Owner/Leader</td>
<td>Medicine Unit Director</td>
</tr>
<tr>
<td>Key Team Members</td>
<td>Medicine Unit Nurse</td>
</tr>
<tr>
<td></td>
<td>Emergency Department Nurse</td>
</tr>
<tr>
<td></td>
<td>Microbiologist</td>
</tr>
<tr>
<td></td>
<td>Infection Preventionist</td>
</tr>
<tr>
<td></td>
<td>Staff Pharmacist</td>
</tr>
<tr>
<td></td>
<td>Housekeeping Supervisor</td>
</tr>
</tbody>
</table>
Case Study

• The initial Team meeting was scheduled as a three hour event to develop a performance improvement plan. The Chief Nursing Officer ensured directors had covered other duties of the Team members during the meeting time so that patient care would not suffer.

• The Chief Nursing Officer presented:
  – Current statistics for CDI
  – Project goal
  – Project scope
  – Resources for best practices for CDI prevention

• The Quality Improvement Director provided “just in time” training on the hospital’s PDSA method for performance improvement and covered team ground rules.
Quality Improvement PDSA Cycle

Specific measure with numerator and denominator

Specific goal and timeframe

Adopt/adapt best practices

Use this cycle for each process identified for quality improvement
Rapid Cycle Process Change

Multiple short tests of change completed in order to maximize performance improvement
Team Ground Rules

- All team members and opinions are equal.
- Team members will speak freely and in turn.
  - We will listen attentively to others.
  - Each must be heard.
  - No one may dominate.
- Problems will be discussed, analyzed, or attacked (not people).
- All agreements are kept unless renegotiated.
- Once we agree, we will speak with “one voice” (especially after leaving the meeting).
- Honesty before cohesiveness.
- Consensus versus democracy: we each get our say, not our way.
- Silence equals agreement.
- Members will attend regularly.
- Meetings will start and end on time.
Case Study

The Chief Nursing Officer presented the Team with the histogram of likely causes of increased CDI ratios, and allowed members to think of any other items to be added. None were given.

The Quality Improvement Director then had the Team to rank each of the 9 items from highest to lowest priority, and then summarized them onto a histogram.
Case Study, cont.

Increased CDI Ratio

Environment
- Isolation delays
- Room Cleaning
- Antibiotic Overutilization
- Lab testing sensitivity

Method
- Late orders for cultures
- Inappropriate stool specimens
- Poor hand washing
- Physicians Culturing asymptomatic patients
- Patient/Family/Visitor Awareness

Equipment/Meds

People
Case Study

Team Ranking of Likely Causes of Increases in C. Difficile Infections

Histogram
Case Study

• Team members evaluated the histogram, and determined that the top six “likely causes” could be divided into two areas of opportunity.

**Improve the Environment**

• Hand washing
• Room Cleaning
• Isolation Precautions

**Specimen Collection and Culturing**

• Inappropriate stool specimens
• Late stool cultures
• Culturing stools of asymptomatic patients
Case Study

The Team determined that it would break into two sub-groups in order to most effectively address top opportunities.

The Infection Preventionist and Housekeeping Supervisor led efforts for “improving the environment”.

The Medicine Director and Microbiologist led efforts for “improving specimen collection and culturing”.

Other team members were assigned to one of the two groups.
### Case Study

**General Timeline for Performance Improvement Project**

<table>
<thead>
<tr>
<th>Activity</th>
<th>Begin</th>
<th>End</th>
</tr>
</thead>
<tbody>
<tr>
<td>Evaluate policies and procedures against best practices</td>
<td>2/1</td>
<td>2/28</td>
</tr>
<tr>
<td>Assess employee knowledge of CDI prevention</td>
<td>2/15</td>
<td>3/15</td>
</tr>
<tr>
<td>Identify policy/practice changes needed and plan to implement</td>
<td>2/1</td>
<td>3/31</td>
</tr>
<tr>
<td>Obtain approvals for policy changes and implementation plan</td>
<td>3/31</td>
<td>4/15</td>
</tr>
<tr>
<td>Educate medical staff and nursing on policy changes</td>
<td>4/15</td>
<td>5/15</td>
</tr>
<tr>
<td>Implement policy changes</td>
<td>5/16</td>
<td></td>
</tr>
<tr>
<td>Ongoing staff observation, mentoring and remediation</td>
<td>5/16</td>
<td>7/16</td>
</tr>
<tr>
<td>Data collection, evaluation and fine tuning of process changes</td>
<td>7/16</td>
<td>-----</td>
</tr>
</tbody>
</table>
Case Study
Four Week Progress Report – Environmental Subgroup

• Staff knowledge of best practices for CDI prevention by hand washing rather than use of alcohol gel assessed via one-on-one conversations – 20 out of 30 employees interviewed responded correctly (66%)
  – Policy and procedure reviewed and up to date
  – IP and Nursing Directors had identified a best practice poster and this was posted on every nursing unit and in the physician lounges

• Policy and procedure for environmental cleaning was reviewed and need for updates noted. Policy revisions were presented in draft form and approved by Chief Nursing Officer.
  – Housekeeping Supervisor and IP developing an in-service for housekeeping staff as well as competency checklist.
Case Study
Four Week Progress Report – Environmental Subgroup

• Current isolation policy and procedures for patients presenting and suspicious for *C. difficile* were reviewed. Policy/process changes recommended included:
  – Implementation of isolation on patient presentation to the Emergency Department
  – Communication of isolation status to staff on floor on patient admission
  – Continuation of isolation status until initial stool cultures are received, then discontinue if stool culture negative

• Chief of staff to present the policy and procedure changes to Medical Executive Committee for approval

• Infection Preventionist and Emergency Department nurse developing a training module for all nursing staff.
Case Study
Four Week Progress Report – Specimen Subgroup

• Subgroup had reviewed best practices and determined that there was currently NO policy relevant to stool specimen collection for *C. difficile*
  – Subgroup presented a proposed policy for stool specimen collection which included a process for rejection of specimens not meeting criteria as well as a “do not culture” process for asymptomatic patients
  – Subgroup also presented a proposed nurse-driven protocol for ordering of stool specimens for patients with signs and symptoms of *C. difficile* infection

• Chief of staff to present policy and procedure changes to Medical Executive Committee for approval

• Microbiologist and Medicine developing a training module for nursing and laboratory staff

• Pharmacist presented an article for the Pharmacy Newsletter which is widely read by the medical staff. In addition to best practices for stool cultures, the Pharmacist also included best antibiotic practices in the article.
The Team determined key measures they would use to evaluate Team progress in achieving goals. They were:

- % of nursing staff attending in-service
  • Target: 128/128 – 100%

- % of staff able to verbalize appropriate hand hygiene when interviewed (30 cases per month)
  • Target: 30/30 – 100%

- % of ED nursing staff able to verbalize isolation practices for patients presenting with signs and symptoms of \textit{C. difficile} (30 interviews per month)
  • Target: 30/30 – 100%
Case Study
Environmental Subgroup  Key Measures Established

• The Team determined key measures they would use to evaluate Team progress in achieving goals. They were:
  – % of nursing housekeeping staff successfully completing competency exam
    • Target: 22/22 – 100%
  – % of housekeeping staff appropriately cleaning rooms of patients in isolation for CDI when observed
    • Target: 100%
  – Concurrent review of 100% of patients presenting with signs and symptoms of *C. difficile* for appropriate isolation on arrival
    • Target: 100%
Case Study
Specimen Subgroup – Key Measures Established

• The Team determined key measures they would use to evaluate Team progress in achieving goals. They were:
  – % of inappropriate stool samples received by Lab
    • Target: Less than 5%
  
  – % of patients presenting with signs/symptoms of CDI with culture results within 72 hours
    • Target: 100%
  
  – % of *C. difficile* cultures ordered on asymptomatic or inappropriate patients (review of 1st 30 cultures monthly)
    • Target: 0/30 – 0%
Case Study

- The Team was highly motivated and organized with everyone accomplishing their assignments by established deadlines.

- The Chief of Staff was instrumental in addressing any medical staff concerns over changes in policies and procedures. He intervened directly with two medical staff members reluctant to have a nurse–driven protocol for specimen collection and policy for rejection, sharing published best practices with them.

- 100% of employees received targeted education and training regarding CDI prevention. Training was also added to new employee orientation and annual competency exams.

- Key metrics were posted on all nursing units, in Housekeeping, and in Pharmacy and Laboratory.
Case Study

• The Team Nurses served as mentors during the implementation of nursing process changes and were invaluable in motivating nurses to consistently apply best practices.

• The IP monitored CDI events and reported to the Team at each meeting. She also provided updated trending reports as available.

• The Chief Nursing Officer provided reports to the Quality Council and Patient Safety Committee.

• The Chief of Staff provided reports to the Medical Executive Committee.
Case Study

• At the end of six months, key quality metrics were at targets and SIRs were approaching, but slightly above, national average

• The Pharmacist, the Chief of Staff, the Infection Preventionist, the Microbiologist and two interested members of the medical staff implemented an Antimicrobial Stewardship Program with an initial focus on *C. difficile* infection reduction.

• Other Team members developed a Patient/Family/Visitor education toolkit on CDI (using resources from the CDC and Quality Insights) and successfully implemented it.
Case Study

Happy Ending

At the end of twelve months, SIRs were better than national average.

Approximately 25 fewer patients experienced healthcare acquired CDI in the last quarter (based on historical projections).

At the Spring Annual Employee Picnic, the CDI Prevention Team was recognized as the Performance Improvement Team of the Year.
I Hope I’ve Enabled You to Move Forward With Mainstreaming Quality Improvement !!!!

Go and create the culture of the goose!
AND, One Final Thought…

“When you wake up, think about winning the day.

If you are worried about the mountain in the distance, you might trip over the molehill right in front of you.”

― Drew Brees
Questions?

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