Learn It, Lead It, Live It: Strategies for Driving Change to Impact Patient Outcomes

Kathleen Vollman MSN, RN, CCNS, FCCM, FAAN
Clinical Nurse Specialist, Educator, Consultant
ADVANCING NURSING LLC, Northville MI
kvollman@comcast.net

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Session Objectives & Content

• Understanding the driving factors for the need to resuscitate the basics
• Defining the role of an Collaborative Leader
• Skills for making change happen
• Identification of tools/models to lead & add value to frontline practitioners & improve outcomes
Hard Work Ahead

Fun and Inspiring
“It may seem a strange principle to enunciate as the very first requirement in a Hospital that it should do the sick no harm.”

Florence Nightingale

**Advocacy = Safety**
Protect The Patient From Bad Things Happening on Your Watch

Implement Interventional Patient Hygiene
Interventional Patient Hygiene

- Hygiene…the science and practice of the establishment and maintenance of health
- Interventional Patient Hygiene….nursing action plan directly focused on fortifying the patients host defense through proactive use of evidence based hygiene care strategies

Incontinence Associated Dermatitis Prevention Program
INTERVENTIONAL PATIENT HYGIENE (IPH)

VAP/HAP

Oral Care/ Mobility

HAND

Patient

HYGIENE

Catheter Care

Skin Care/ Bathing/Mobility

CA-UTI

CA-BSI

SSI

HASI

Vollman KM. Australian Crit Care, 2009;22(4): 152-154
Achieving the Use of the Evidence

Factors Impacting the ability to Achieve Quality Nursing Outcomes at the Point of Care

Vollman KM. Australian Crit Care, 2009;22(4): 152-154
Drive The Vision

Healthcare Without Infections
Protecting Patients From Harm

<table>
<thead>
<tr>
<th>Estimates</th>
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<tbody>
<tr>
<td>HAI:</td>
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<tr>
<td>1.7 million/year</td>
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<tr>
<td>HAI-related deaths:</td>
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<tr>
<td>100,000/year</td>
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<tr>
<td>Hospitalized patients develop infection:</td>
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<tr>
<td>1 out of 17</td>
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<td>Death due to sepsis/septic shock:</td>
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<td>700/day</td>
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<td>Money spent:</td>
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<td>$45 billion/year</td>
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<tr>
<td>Increase risk of readmission:</td>
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<td>27 days vs. 59 days</td>
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Factors Impacting HAI’s Programs

- Factors Associated with Lower HAI’s (30% reduction)
  - Integrated infection control program
  - Culture change
  - Leadership/Champion
  - Use of proven best practices
  - HAI surveillance

and always remember, my child...... only dead fish go with the flow.
Four Competency Domains

Leadership Competency Domain

- Leadership: Leadership is based on influence rather than authority and this influence is a consequence of skills in 5 content categories
  - Collaboration
  - Followership
  - Program management
  - Critical Thinking
  - Communication

Environmental Agitator
Why a Collaborative Leader/Consultant Model Approach?

- Collaborative Leader/Consultant Model Approach
  - Collaboration in the development of policies & procedures
  - Total engagement of specialist and frontline to ensure success
- One-size does not fit all
- Customized solutions & flexible policies
- “You can’t do this” to “how can we help you get things done”
- Commitment to ongoing relationship that fosters earlier preventive involvement

The only limit to what you can achieve is the extent of your ability to define what it is you want and the Persistence & Passion to get it.
Personal SWOT Analysis

- STRENGTHS
- WEAKNESSES
- OPPORTUNITIES
- THREATS
• **Strengths**: Skills and abilities you possess that will help you get develop the role, utilize your expertise and sustain the passion and commitment

• **Kathleen’s**: Professional speaking, love people, skill of networking, my passion for nursing and life, my drive, my organizational skills, ability to juggle multiple things at a time
Weaknesses

- **Weaknesses:** What skills and abilities I might not possess that I will need to make this happen?

- **Kathleen’s:** Creating balance in my life, working with databases, listening skills, and rushing through life without smelling the roses.
Opportunities

• **Opportunities:** What areas exist for potential personal and professional growth that I need to work on in order to succeed?

• **Kathleen’s:** Using software for project planning, slowing down to enjoy the journey vs. the end product, realistic negotiation related to times and projects.
Threats

- **Threats**: What are the things that can impede my growth or get in the way of me succeeding?

- **Kathleen’s**: self doubt, not listening for understanding, time, over commitment because I can’t say no, perfectionism
I wake up every morning, torn between a desire to save the whales, attain enlightenment, visit the Dalai Lama or go back to bed.

Makes it kinda hard to plan the day.
Bucket Board
Looking Through A Different Lens

We Must be Visible at the Frontline!!
“If your actions inspire others to dream more, learn more, do more, and become more, you are a Leader”

John Quincy Adams
Understanding How You Influence

- **Legitimate Power**
  - Authoritative power derived from a job, position, or status and held as belonging to the person in such a position.

- **Expert Power**
  - Based on a person’s expertise, competence, and information in a certain area.

- **Referent Power**
  - Based on a high level of identification with, admiration of, or respect for the power holder/leader.

Power is the engine that drives the ability to influence.
“Setting an Example is Not the Main Means of Influencing Others….It is the Only Means”

Albert Einstein
Leadership Domain Example

  - 35 hospitals in 5 different regional collaboratives support by AHRQ
  - Lesson learned: understand the resistance, commit to regular communication & join the collaborative, start small and tailor implementation to local cultures, engage frontline staff

  - Multidisciplinary team plan and implement 5 core evidence based CDI prevention strategies. CDI PCR assay test implemented (rates increased) over 2 yrs of implementation went from 7.90 cases per 10,000 pt days to 3.73 cases. 52% reduction
Change and growth take place when a person has risked himself & dares to become involved with experimenting with his own life

Herbert Otto
Blessed Are The Flexible
For They Shall Never
Be Bent Out Of Shape

Ohmagawd! What was I thinking?
IPC Competency Domain

• IP’s competencies are the foundation of the IP’s development being subject matter experts in epidemiology and natural history of infection
  – Epidemiology and Surveillance
  – Risk Assessment
  – Risk Reduction and Infection Prevention
  – Use & interpretations of dx tests
  – Antimicrobial stewardship
  – Education, Evaluate and Use Research

It is not enough to do your best; you must know what to do, and THEN do your best.

~ W. Edwards Deming
• Scrub the Hub:
  - Scrubbing the access port with an appropriate antiseptic (chlorhexidine, povidone iodine, an iodophor, or 70% alcohol) and accessing the port only with sterile devices.(IA)
  - 3 sec, 10 sec showed no difference in reducing bacterial load, 15sec trended towards significance (Simmons S, et al. Crit Care Nurs Q, 2011;34:31-35)
  - 3 phase multicenter quasi-experimental study looking at continuous passive disinfection over three time periods; usual practice, CPD, usual practice. Demonstrated 40% reduction in CLA-BSI’s (Wright, M et al Am J Infect Control, 2013;41:33-8)
  - Quality Improvement Project: CUSP in combination with BSI insertion bundle (7.6 to 2.12/1000 catheter days), added 2% CGH bathing & Maintenance bundle (2.12 to .70 per 1000 catheter days), then CPD .70 to zero per 1000 catheter days (Posa, P. Presented at APIC Annual conference, Fort Lauderdale, 06/13)
“One’s mind, once stretched by a new idea, never regains its original dimensions.”

Oliver Wendell Holmes
“Even if you are on the right track, you will get run over if you just sit there.”

Will Rogers
Technology Competency Domain

- Surveillance of HAI’s requires data collection, collaboration, analysis and dissemination of findings.
  - Information technology support
  - Surveillance Technology
  - EMR & EDW

Knowledge in Technology

• Electronic data collection is beneficial if the data means something and results in actionable events

• APIC Poster 2013: Facility Level Dashboard Utilized to Decrease Infection Preventionist Time in Disseminating Data (Mayfield J and team from Barnes Jewish Hospital in St Louis)
  – Antiquated and time consuming process for data gathering and reporting
  – Streamline data from ICU’s and oncology
  – Utilized data visualization software to create automated dashboard for CLA-BSI and VAP
  – Dashboard included individual unit displays and NHSN benchmarks
  – ↓ amt of time packaging data by 60 to 90 minutes per area per month (11-16 hrs saved)
You miss 100 percent of the shots you never take.”    Wayne Gretzy
4th Domain: Performance Improvement & Implementation Science

• PI encompasses all of the system projects, team activities that organizations use to achieve the goals
• Implementation science study of methods to promote uptake of clinical research findings and make them the new routine
  – Identification of need
  – Team Assembly
  – Tools & Methods
  – Implementation
  – Measuring success

Activity without purpose is the drain of your resources
Translating Evidence into Practice (Johns Hopkins Model)

1. Summarize the Evidence
   - Identify interventions associated with improved outcomes
   - Select interventions with the largest benefits and lowest barriers to use
   - Convert interventions to behaviors
   - Observe staff performing the interventions
     - “Walk the process” to identify defects in each step of intervention implementation
     - Enlist all stakeholders to share concerns and identify potential gains/losses associated with intervention implementation

2. Identify local barriers to implementation: understand the process and context of work
   - Select Measures (Process and/or outcome)
   - Develop and pilot test measures
   - Measure Baseline Performance

3. Measure Performance
   - Engage
     - Explain why the interventions are important
   - Evaluate
     - Regularly assess performance measures
   - Execute
     - Design an intervention on “toolkit” targeted to barriers employing standardization, independent checks and reminders, and learning from mistakes
   - Educate
     - Share the evidence supporting the interventions

4. Ensure all patients receive the interventions

Translating Evidence into Practice

- Envision the problem within the larger health care system
- Engage Collaborative multi-disciplinary teams centrally (stages 1, 2 & 3) and locally (stage 4)
### 4 E’s: Implementation Framework

<table>
<thead>
<tr>
<th></th>
<th>Frontline Staff</th>
<th>Team Leaders</th>
<th>Senior Executives</th>
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<tbody>
<tr>
<td><strong>Engage</strong></td>
<td>Ask, how does this make the world a better place?</td>
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<td></td>
<td>– Help staff understand the preventable harm</td>
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<td>– Share stories about patients affected</td>
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<td>– Estimate number of patients harmed</td>
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<td></td>
<td>– Develop a business case</td>
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<tr>
<td><strong>Educate</strong></td>
<td>What do I need to do?</td>
<td></td>
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</tr>
<tr>
<td></td>
<td>– Convert evidence into behaviors;</td>
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<td></td>
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<td></td>
<td>– Evaluate awareness and agreement</td>
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<tr>
<td><strong>Execute</strong></td>
<td>How can I do it?</td>
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<tr>
<td></td>
<td>– Listen to resisters</td>
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<td>– Standardize, create independent checks</td>
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<td></td>
<td>– Make it easy to do the right thing</td>
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<td></td>
<td>– Learn from mistakes</td>
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<td><strong>Evaluate</strong></td>
<td>How do I know we made a difference?</td>
<td></td>
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<tr>
<td></td>
<td>– Define measures</td>
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<tr>
<td></td>
<td>– Develop a business case</td>
<td></td>
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<tr>
<td><strong>CLABSI</strong></td>
<td>➢ Overview with staff that CLABSI are preventable</td>
<td></td>
<td>➢ Also share P4P measures</td>
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<tr>
<td></td>
<td>➢ Review incidence of CLABSI</td>
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<td></td>
<td>➢ Share CLABSI rate with team and frontline staff</td>
<td></td>
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<tr>
<td></td>
<td>➢ Share stories of individual cases of CLABSI from this hospital or unit and impact on the patient</td>
<td></td>
<td>➢ Define business case—what does each BSI cost our institution</td>
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<tr>
<td><strong>CLABSI</strong></td>
<td>Convert evidence into behaviors</td>
<td>Define their role</td>
<td>Ask executives if need assistance with getting products or support from medical staff</td>
</tr>
<tr>
<td>Insertion bundle</td>
<td>Maintenance bundle</td>
<td>Get medical leadership support for stopping line insertion</td>
<td></td>
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<tr>
<td>Empower nurses to stop line insertion if best practice not followed</td>
<td>Create/update central line policies</td>
<td></td>
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<tr>
<td>Change bathing practices</td>
<td>Educate medical staff/residents/mid-level providers on proper insertion techniques</td>
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<tr>
<td>Simulation</td>
<td>credentialing</td>
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</thead>
</table>
| **Execute** | How can I do it?  
- Listen to resisters  
- Standardize, create independent checks  
- Make it easy to do the right thing  
- Learn from mistakes | | |
| **CLABS** | Create line cart  
Develop line insertion checklist  
Ensure nurse in room during line insertion to complete checklist  
Establish pre-procedure briefing process  
Add to multidisciplinary rounds—can this line be removed  
Learn from each defect---each CLABS  
2% CHG bathing  
Passive disinfection caps | Hold staff accountable for new process | Remove barriers  
Support checklist |
### 4 E’s: Implementation Framework

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<td></td>
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<tr>
<td></td>
<td>- Regularly assess measures</td>
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<tr>
<td><strong>CLABSI</strong></td>
<td>- Measure CLABSI rate monthly and share with staff</td>
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<tr>
<td></td>
<td>- Measure compliance with insertion and maintenance bundles</td>
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<tr>
<td></td>
<td>- Learn from each defect—review each CLABSI with team and staff</td>
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<td></td>
<td>- Share at staff meetings</td>
<td>Share at</td>
<td>Ask for</td>
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<td></td>
<td>- Support staff in LFDs</td>
<td>staff meetings</td>
<td>performance</td>
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<tr>
<td></td>
<td>- Support staff in LFDs</td>
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<td>measures</td>
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<td></td>
<td>- Ask for performance measures</td>
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<td>Share with</td>
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<td>- Share with board</td>
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<td>board</td>
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</table>
IF AT FIRST YOU DON'T SUCCEED, YOU'RE RUNNING ABOUT AVERAGE.
Implementation Science Examples

• What does it take to change a practice?
  – Human factor engineering
    • Focus on the work systems or the conditions under which persons work
    • Structural work leads to process development then outcome
    • Designs systems to support human performance
    • Force Function behavior: the process of building defenses to avert error or mitigate their effects

Implementation Strategies for Successful Change in Practice

- All lines including peripherals IV’s for anyone inpatient
  - If the end user needs to think which lines get them and which don’t, less likely to occur
- Excluded ER/OR and procedural areas
  - Limited exposure and less controlled environment

Measuring Compliance
### Drilling Down to the Details

#### Patients
- If just one patient in room, please indicate with letter A. If more than one in room, continue to indicate with B, C, etc.

<table>
<thead>
<tr>
<th>Room #</th>
<th>Patients</th>
<th>Total Unused Valves (# of valves not connected to cont/intermit IV. Include peripheral, central, continuous lines)</th>
<th>Total Unused Valves w/disinfection caps - (# of disinfection caps placed on available valves)</th>
<th>% of disinfection caps being used</th>
<th>Compliant?</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>901</td>
<td>A</td>
<td>2</td>
<td>0</td>
<td>0.0%</td>
<td>X</td>
<td>PIV-Ysites not covered</td>
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<tr>
<td>903</td>
<td>A</td>
<td></td>
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<td>904</td>
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<td>922</td>
<td>A</td>
<td>1</td>
<td>0</td>
<td>0.0%</td>
<td>X</td>
<td>Saline lk</td>
</tr>
<tr>
<td>923</td>
<td>A</td>
<td>1</td>
<td>1</td>
<td>100.0%</td>
<td>X</td>
<td>Saline lk</td>
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<tr>
<td>924</td>
<td>A</td>
<td>3</td>
<td>3</td>
<td>100.0%</td>
<td>X</td>
<td>All Ysites covered</td>
</tr>
<tr>
<td>925</td>
<td>A</td>
<td>1</td>
<td>1</td>
<td>100.0%</td>
<td>X</td>
<td>Saline lk</td>
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<tr>
<td>927</td>
<td>A</td>
<td>1</td>
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<td>100.0%</td>
<td>X</td>
<td>PICC</td>
</tr>
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<td>928</td>
<td>A</td>
<td>1</td>
<td>1</td>
<td>100.0%</td>
<td>X</td>
<td>Saline lk</td>
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<tr>
<td>931</td>
<td>A</td>
<td>1</td>
<td>1</td>
<td>100.0%</td>
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<td>1</td>
<td>1</td>
<td>100.0%</td>
<td>X</td>
<td>Saline lk</td>
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### Continuous Improvement & Sustainability

- Measurement
- Learn from defects
- Review literature
- Tests of change

*Note: Compliant? indicates yes with an X. NO indicates less than 100% of available valves covered with DCs.*

*PICC: Peripherally Inserted Central Catheter*
The Most Powerful Force of Human Behavior is Social Influence
Know The Cultures Your are Working In!!

- SAQ (Safety Attitudes Questionnaire)/AHRQ tool
  - Teamwork
  - Safety
  - Working conditions
  - Job satisfaction
  - Stress recognition
  - Perception of upper management
  - Perception of unit management

Strive for 80%, if > 60% SAQ scores correlates to decreases in clinical outcomes
# CUSP & HAI Interventions

## Adaptive /Cultural

<table>
<thead>
<tr>
<th>CUSP</th>
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<tbody>
<tr>
<td>1. Educate on the Science of Safety</td>
</tr>
<tr>
<td>2. Identify Defects (Staff Safety Assessment)</td>
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<tr>
<td>3. Senior Executive Partnership</td>
</tr>
<tr>
<td>4. Learn from Defects</td>
</tr>
<tr>
<td>5. Implement Teamwork &amp; Communication Tools</td>
</tr>
</tbody>
</table>

## Technical

<table>
<thead>
<tr>
<th>HAI/UTI</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Insertion (assess need)</td>
</tr>
<tr>
<td>2. Maintenance</td>
</tr>
<tr>
<td>a. Assessment &amp; Site Care</td>
</tr>
<tr>
<td>3. Daily assessment for removal</td>
</tr>
<tr>
<td>4. Bathing</td>
</tr>
</tbody>
</table>
“You gain strength, courage and confidence by every experience in which you really stop to look fear in the face. You must do the thing which you think you cannot do.”

Eleanor Roosevelt
Economic Burden of HAI’s: Build The Business Case

- Generated point estimates for attributable cost & LOS
- 5 Major Infections = 9.8 billion
  - SSI’s, CLABSI’s, VAP/VAE, CAUTI’s, C-Diff
- SSI’s (33.7%)
- VAP (31.6%)
- CLA-BSI (18.9%)
- C-Diff (15.4%)
- CA-UTI <1%

Per Case Basis

<table>
<thead>
<tr>
<th></th>
<th>SSI</th>
<th>CLABSI</th>
<th>VAP</th>
<th>CAUTI</th>
<th>C-Diff</th>
</tr>
</thead>
<tbody>
<tr>
<td>Value</td>
<td>$20,785</td>
<td>$45,814</td>
<td>$40,144</td>
<td>$896</td>
<td>$11,285</td>
</tr>
</tbody>
</table>

50% HAI’s Preventable

Zimlichman E, et al. JAMA Intern Med, 2013; 09/02/13 online
Lean Surveillance Transformation
Terry Burger & Deb Fry et al Leigh Valley Health Network, Allentown PA

- Created Standard Work
- Obtained additional staffing resources
- Purchased electronic devices for IP to be mobile
- Redistributed work assignments
WHEN WOULD NOW BE A GOOD TIME TO DO THIS?
Key Take Home Messages

• Self inventory of current skills sets (CHICA Canada)
• Develop a personalize education plan
• Get certified if you are not already-greater understanding & use of the science (Saint S, et al. AJIC;2013:41(2)
• Build a business case for greater resources
• Begin to incorporate the 4 domains of IP competency
  – Join an already established team in the ICU
  – Meet with frontline clinical and administrative leaders
  – Learn the people and the culture

Make it Happen
Leap......
And The Net Will Appear
We all are responsible for the safety of our patients......Be the Collaborative Leader

• “If not this, then what??”
• “If not now, then when??”
• “If not me, then who??”

Sit it Out or Dance