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

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Disclosures

- Eloquest Healthcare
- Sage Products Inc
- Hill-Rom, Inc

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

FUN AND INSPIRING

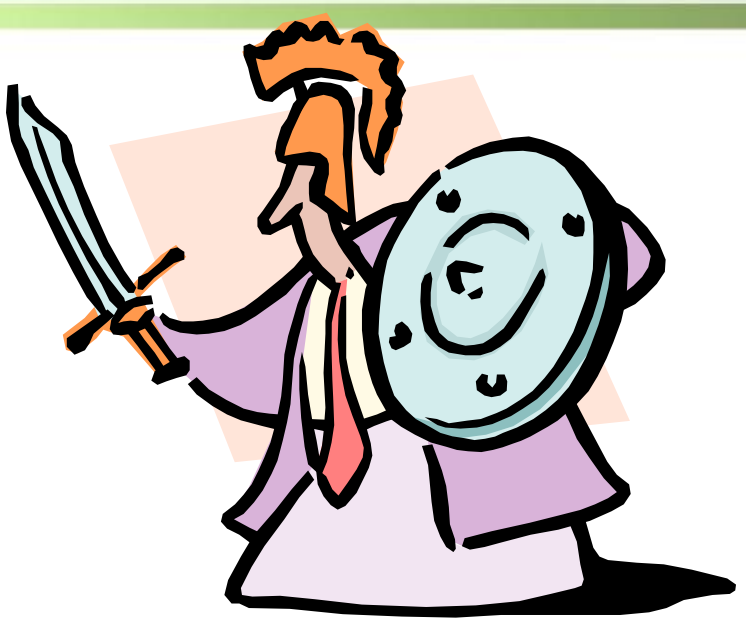
Notes on Hospitals: 1859

"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

Hand Hygiene

Catheter Care

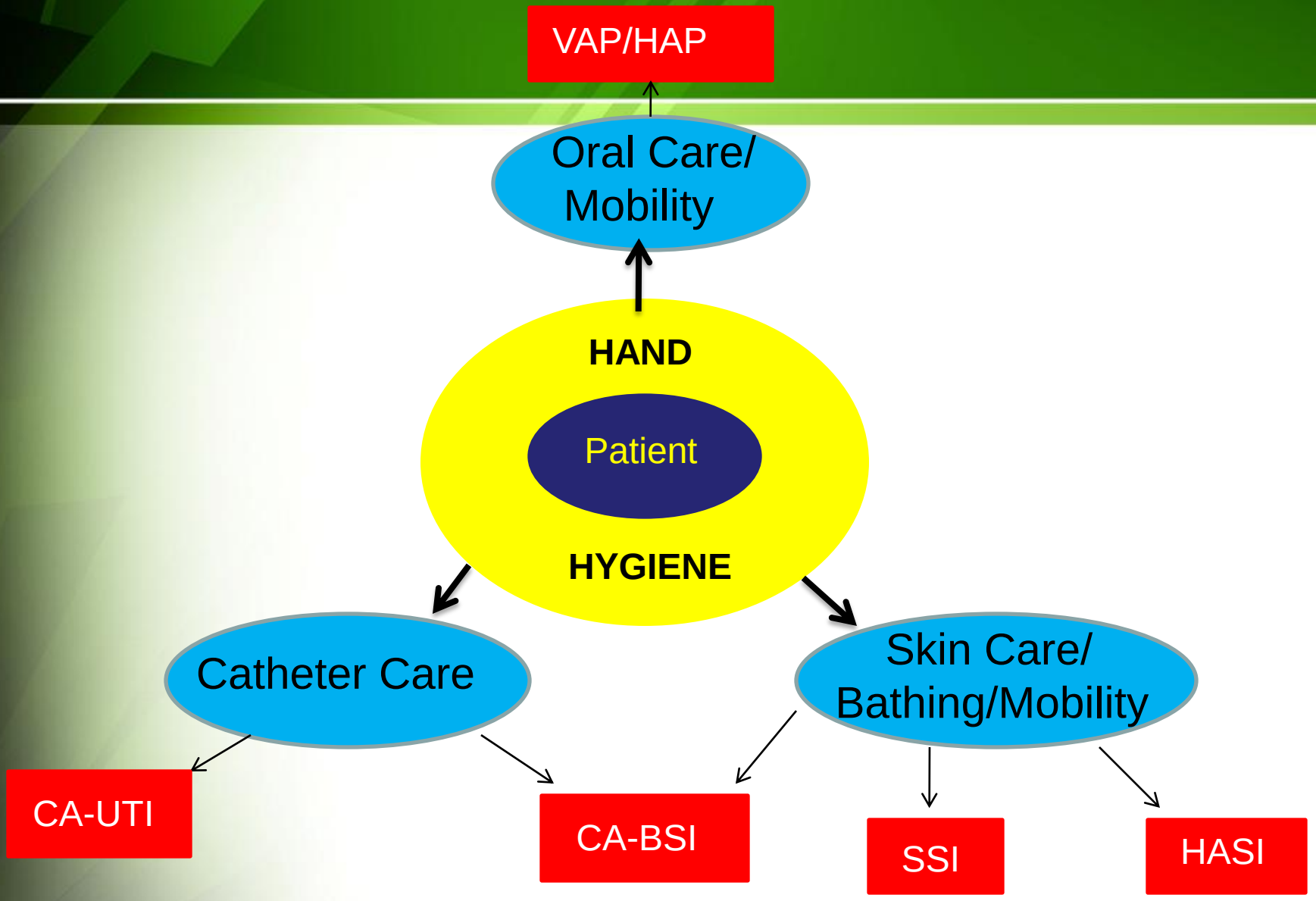
Comprehensive Oral Care Plan

Bathing & Assessment

Incontinence Associated Dermatitis Prevention Program

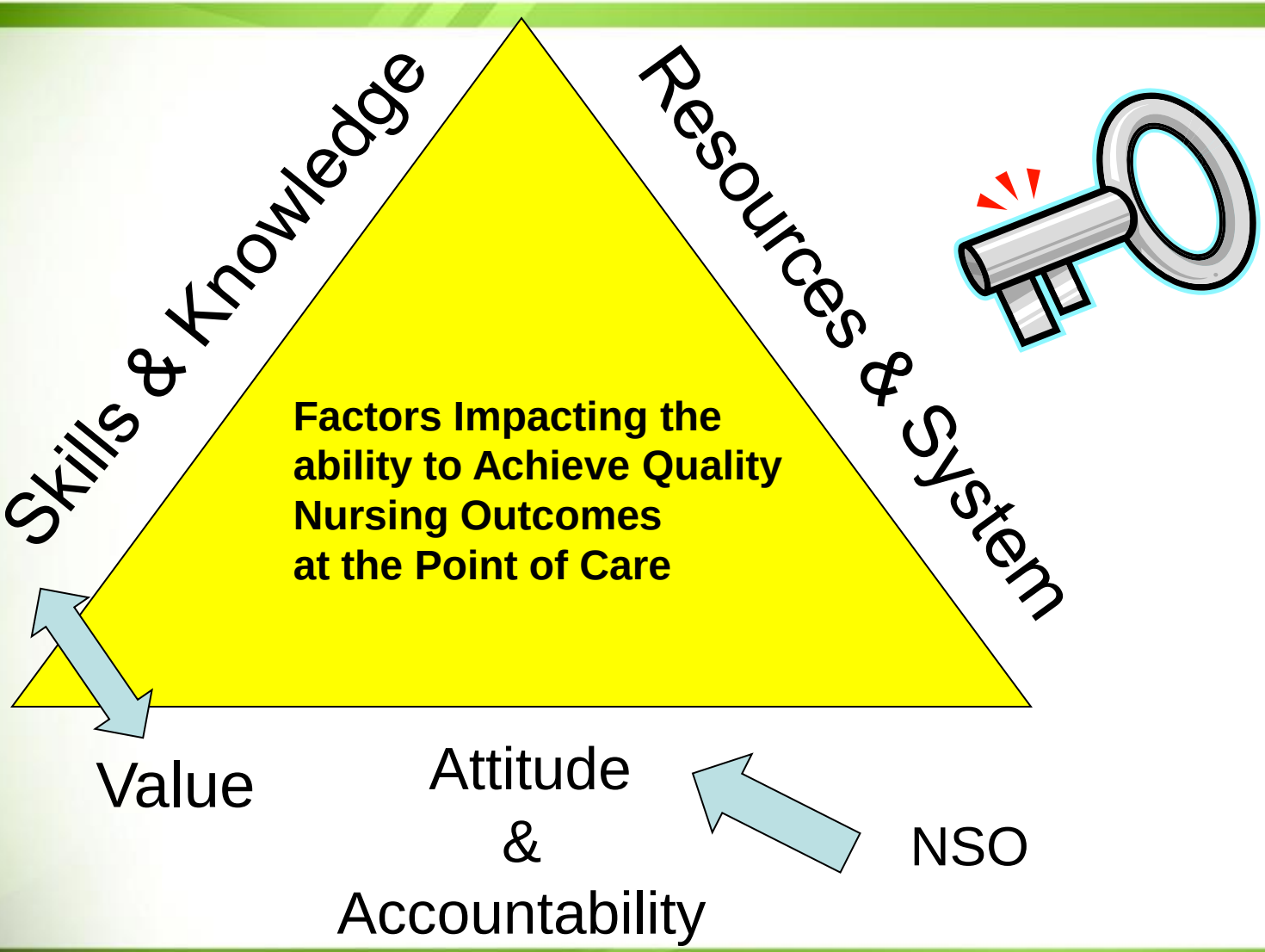
Pressure Ulcer Prevention

INTERVENTIONAL PATIENT HYGIENE(IPH)



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

Achieving the Use of the Evidence



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

Drive The Vision

Healthcare Without Infections

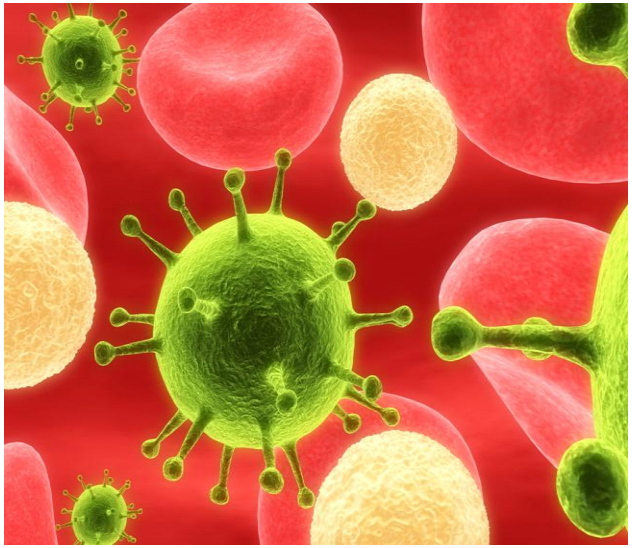
Protecting Patients From Harm

Estimates	
HAI:	**1.7 million/year**
HAI-related deaths:	**100,000/year**
Hospitalized patients develop infection:	**1 out of 17**
Death due to sepsis/septic shock:	**700/day**
Money spent:	**$45 billion/year**
Increase risk of readmission:	**27days vs. 59 days**

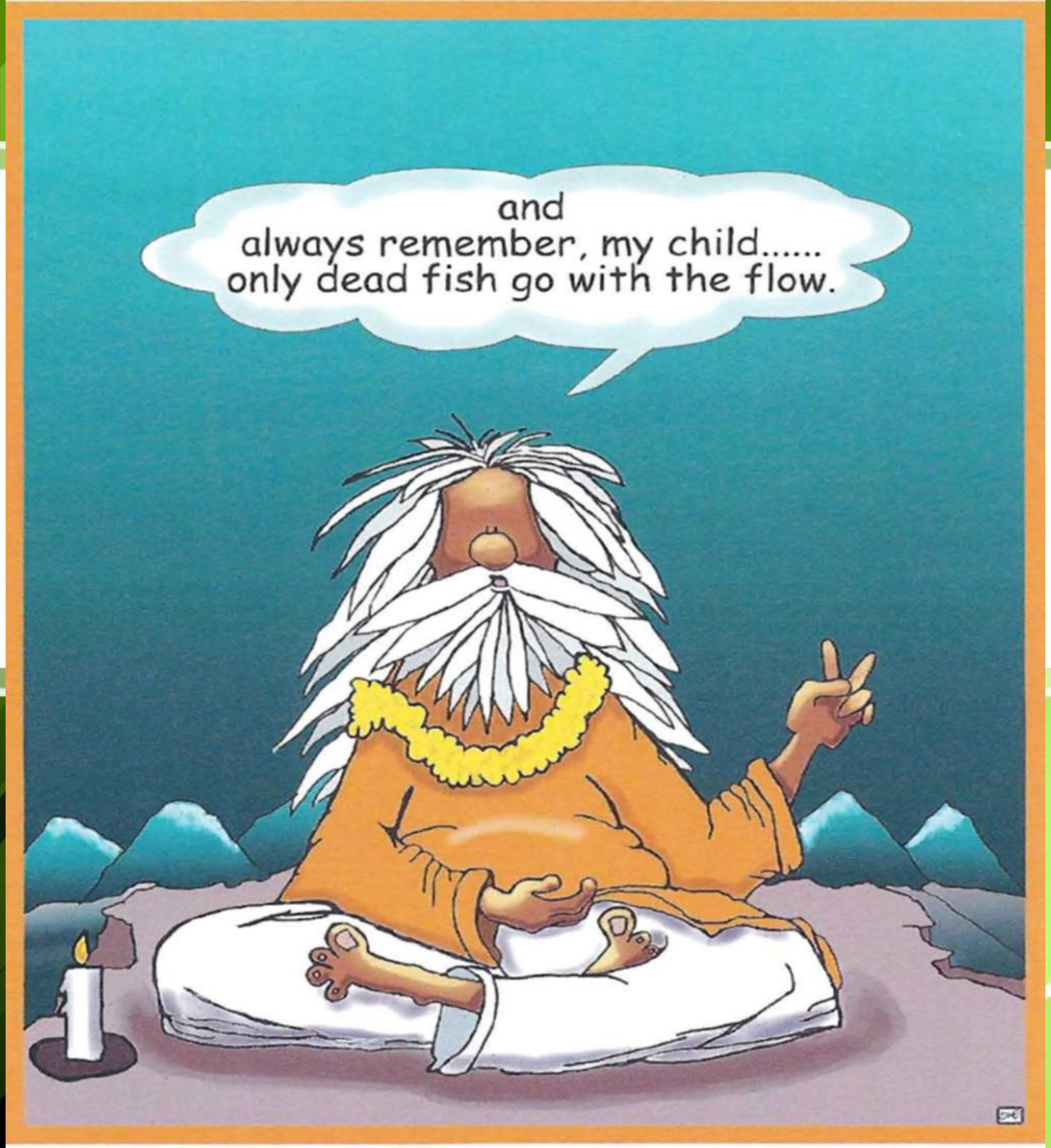
Milstone Am, et al. *Clin Infect Dis*. 2008;46(2):274-281
Klevens RM, et al. *Public Health Rep*. 2007;122:160-166
Burke JP, et al. *N Engl J Med*. 2003;348:651-656
Emerson CB, et al. Infect Control Hosp Epiemiol, 2012:33:539-544

Factors Impacting HAI's Programs

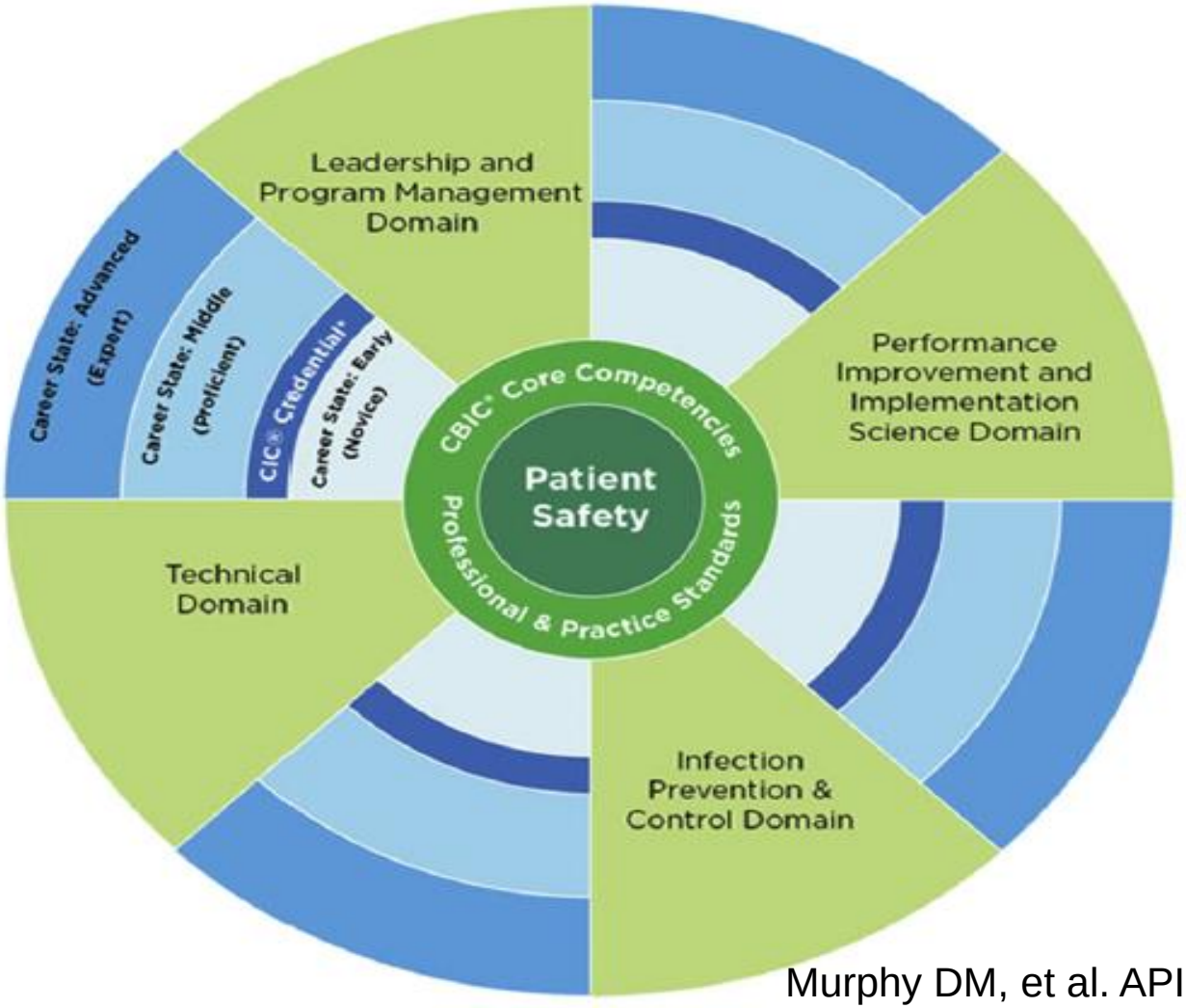
- Factors Associated with Lower HAI's (30% reduction)
  - Integrated infection control program
  - Culture change
  - Leadership/Champion
  - Use of proven best practices
  - HAI surveillance



Rosenthal VD, et al. Am J of Infect Control, 2008;36:el-12
Buñuel N, et al. Crit Care Nurs Quart, 2009;32:144-148


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

Four Competency Domains



Murphy DM, et al. APIC. 2012;40:296-303

Leadership Competency Domain

- Leadership: Leadership is based on influence rather than authority and this influences 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

Murphy DM, et al. APIC. 2012;40:296-303

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

- 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

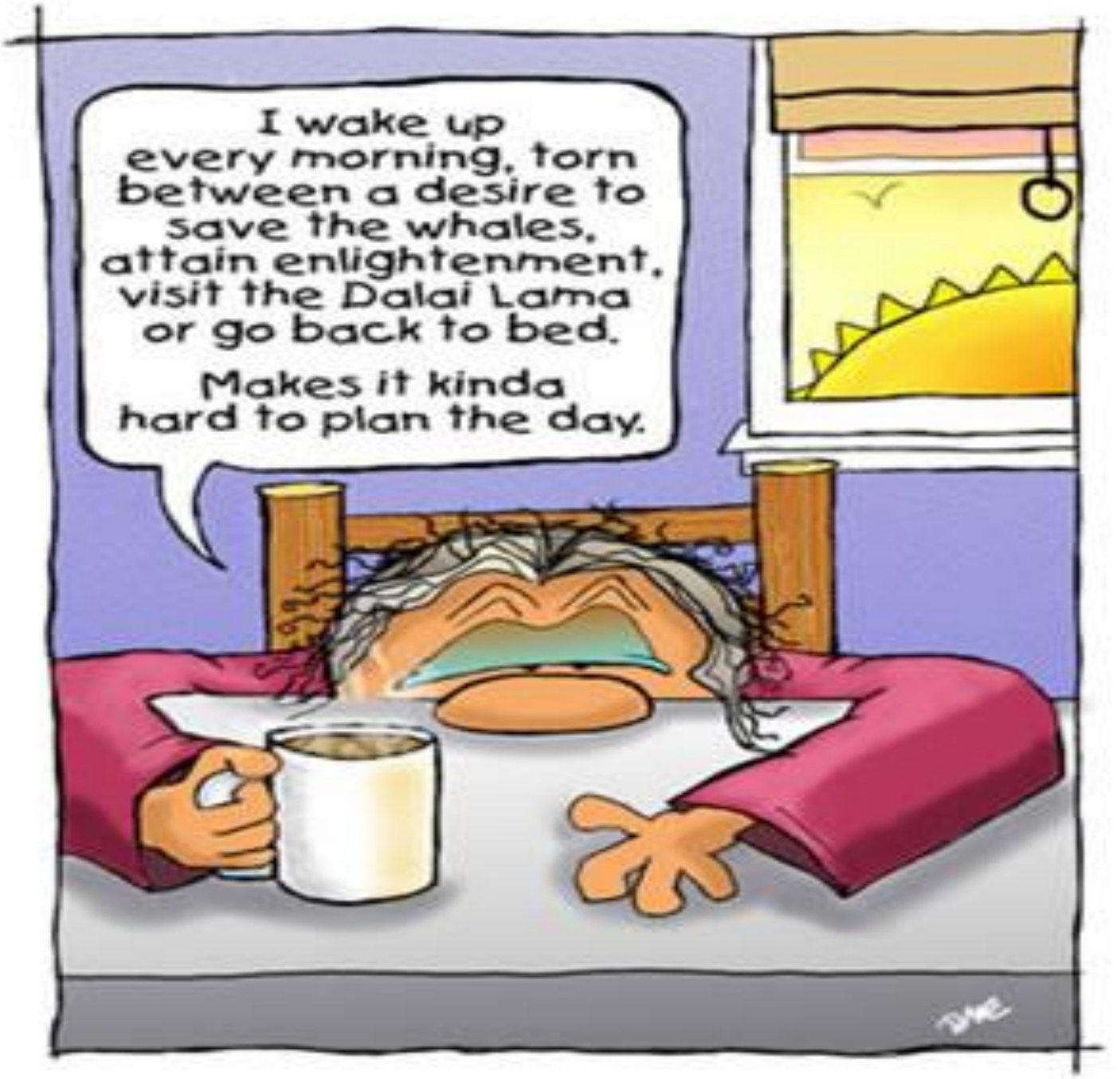
- **Opportunities:** What areas exist for potential personal and professional growth that I need to work on in order to succeed?

- **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

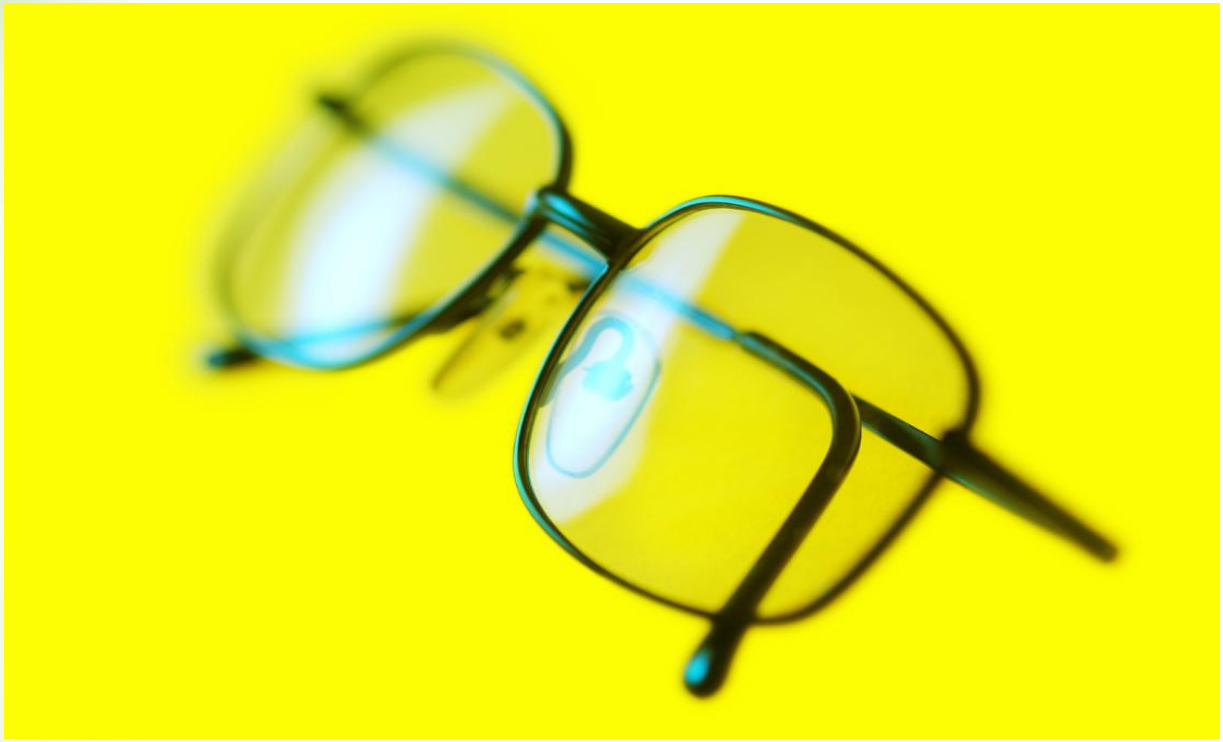
- **Threats:** What are the things that can impede my growth or get in the way of me succeeding?

- **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

- Reducing HAI's: Lessons Learned from National Collaboratives (Welsh CA, et al. AJIC 2012;40:29-34)
  - 35 hospitals in 5 different regional collabortives 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
- Poster 2013 APIC: A Collaborative Approach to Clostridium difficile Infection Prevention: Utilizing EBP Strategies to Improve Patient Outcomes. (Diane Ross & Team from NCH Healthcare System in Florida)
  - 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

Comfort Zone

Change & Challenges

Change and growth take place when a person has risked himself & dares to become involved with experimenting with his own life

Herbert Otto


BUNOY

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

IPC Competency Domain

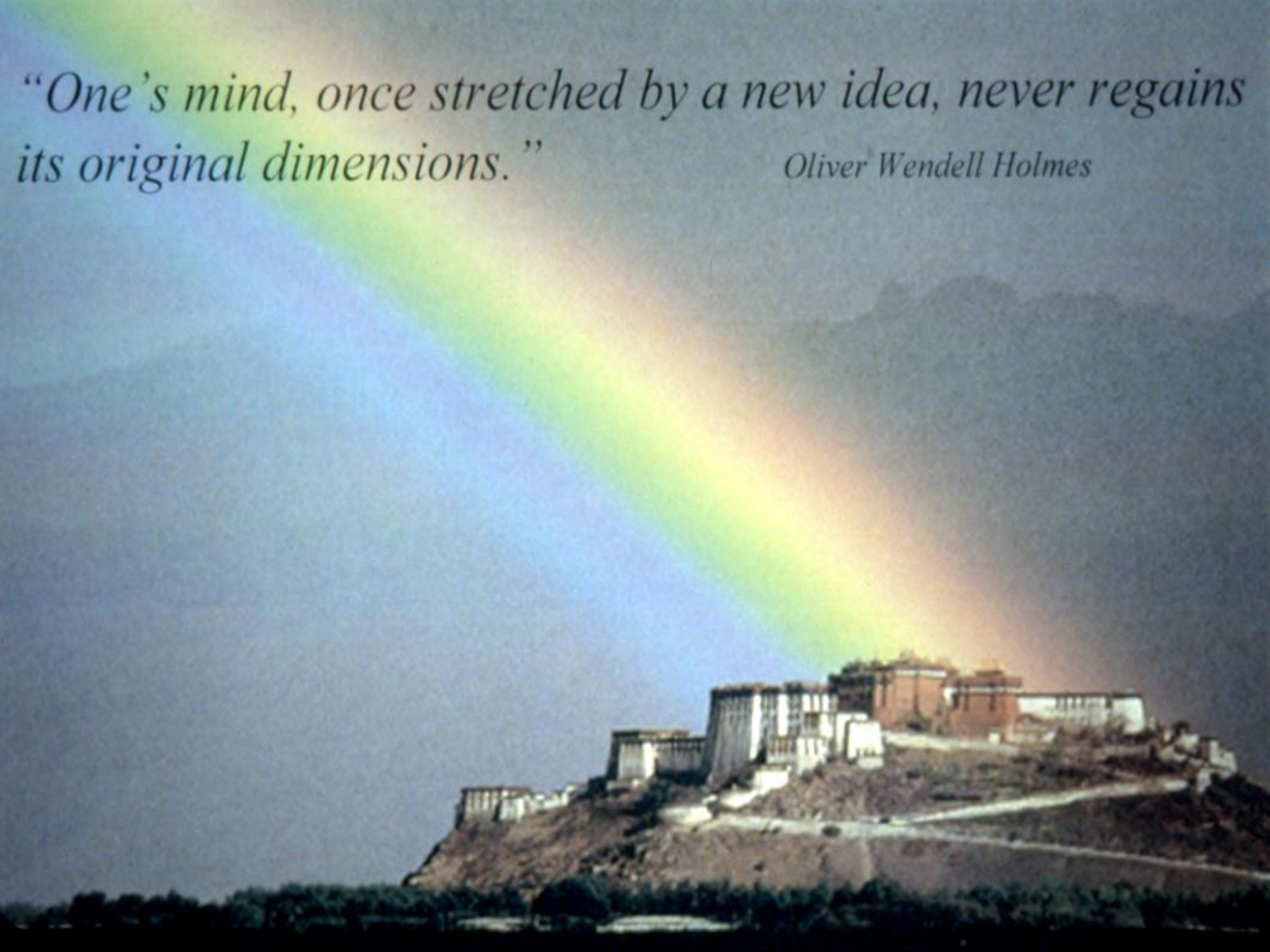
- IP's competencies are the foundation of the IP's development being subject matter experts in epidemiology and natural history of infection
  - Epidemiology and Surveillance
  - Risk Assessment
  - Risk Reduction and Infection Prevention
  - Use & interpretations of dx tests
  - Antimicrobial stewardship
  - 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

Murphy DM, et al. APIC. 2012;40:296-303

IP: Competency Domain

- 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

Murphy DM, et al. APIC. 2012;40:296-303

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

Murphy DM, et al. APIC. 2012;40:296-303

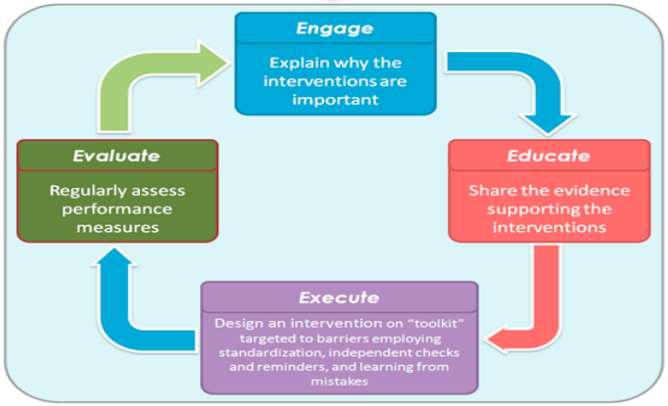

Activity without purpose is
the drain of your resources

Translating Evidence into Practice (Johns Hopkins Model)

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)

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



4 E's: Implementation Framework

	Frontline Staff	Team Leaders	Senior Executives
Engage	Ask, how does this make the world a better place? – Help staff understand the preventable harm – Share stories about patients affected – Estimate number of patients harmed – Develop a business case		
Educate	What do I need to do? – Convert evidence into behaviors; – evaluate awareness and agreement		
Execute	How can I do it? – Listen to resisters – Standardize, create independent checks – Make it easy to do the right thing – Learn from mistakes		
Evaluate	How do I know we made a difference? – Define measures – Regularly assess measures		

4 E's: Implementation Framework

	Frontline Staff	Team Leaders	Senior Executives
Engage	Ask, *how does this make the world a better place?* – Help staff understand the preventable harm – Share stories about patients affected – Estimate number of patients harmed – Develop a business case		
CLABSI	➢ Overview with staff that CLABSI are preventable ➢ Review incidence of CLABSI ➢ Share CLABSI rate with team and frontline staff ➢ Share stories of individual cases of CLABSI from this hospital or unit and impact on the patient	➢ **Also share P4P measures**	➢ **Define business case—what does each BSI cost our institution**

4 E's: Implementation Framework

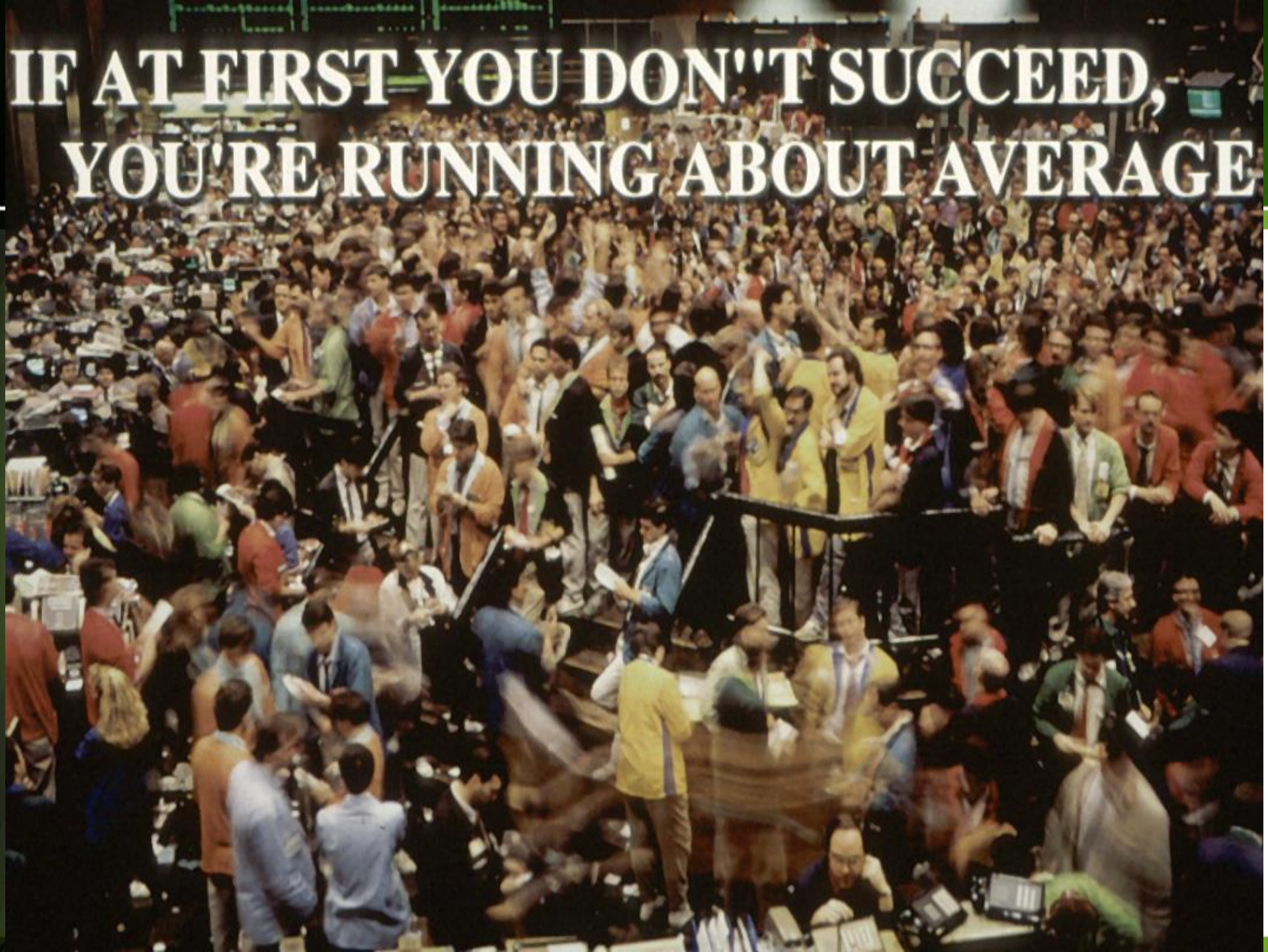
	Frontline Staff	Team Leaders	Senior Executives
Educate	➢ What do I need to do? ➢ Convert evidence into behaviors; ➢ Evaluate awareness and agreement		
CLABSI	➢ Convert evidence into behaviors ➢ Insertion bundle ➢ Maintenance bundle ➢ Empower nurses to stop line insertion if best practice not followed ➢ Create/update central line policies ➢ Change bathing practices ➢ Educate medical staff/residents/mid-level providers on proper insertion techniques ➢ Simulation ➢ credentialing	➢ Define their role ➢ Get medical leadership support for stopping line insertion	➢ Ask executives if need assistance with getting products or support from medical staff

4 E's: Implementation Framework

	Frontline Staff	Team Leaders	Senior Executives
Execute	How can I do it? – Listen to resisters – Standardize, create independent checks – Make it easy to do the right thing – Learn from mistakes		
CLABSI	➢ 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 CLABSI ➢ 2% CHG bathing ➢ Passive disinfection caps	➢ Hold staff accountable for new process	➢ Remove barriers ➢ Support checklist

4 E's: Implementation Framework

	Frontline Staff	Team Leaders	Senior Executives
Evaluate	How do I know we made a difference? – Define measures – Regularly assess measures		
CLABSI	➢ Measure CLABSI rate monthly and share with staff ➢ Measure compliance with insertion and maintenance bundles ➢ Learn from each defect—review each CLABSI with team and staff	➢ Share at staff meetings ➢ Support staff in LFDs	➢ Ask for performance measures ➢ Share with board


IF AT FIRST YOU DON'T SUCCEED,
YOU'RE RUNNING ABOUT AVERAGE

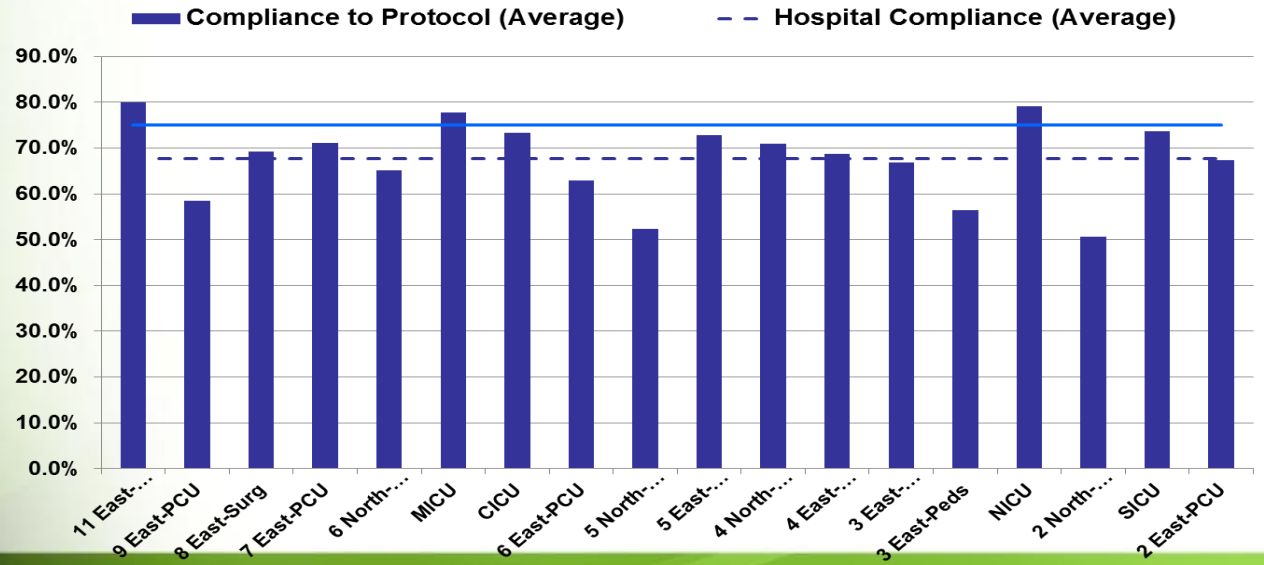
Implementation Science Examples

- 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

The science of human factors: separating fact from fiction. Russ, A, et al Quality and Safety in Healthcare. 2013

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

Room #	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….	Total Unused Valves (# of valves not connected to cont/intermit IV. Include peripheral, central, continuous lines)	Total Unused Valves w/disinfection caps - (# of disinfection caps placed on available valves)	% of disinfection caps being used	Compliant?		Comments
					YES- 100% of available valves covered with DCs - Indicate with an X	NO- Less than 100% of available valves covered with DC - Indicate with an x	
901	A	2	0	0.0%		X	PIV-Ysites not covered
903	A						
904	A						
906	A						
907	A						
908	A						
909	A						
911	A						
912	A						
913	A						
914	A						
915	A						
916	A						
917	A						
918	A						
919	A						
920	A						
921	A						
922	A	1	0	0.0%		X	Saline lk
923	A	1	1	100.0%	X		Saline lk
924	A	3	3	100.0%	X		All Ysites covered
925	A	1	1	100.0%	X		Saline lk
927	A	1	1	100.0%	X		PICC
928	A	1	1	100.0%	X		Saline lk
931	A	1	1	100.0%	X		Saline lk
932	A	1	1	100.0%	X		Saline lk

Continuous Improvement & Sustainability

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


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

CUSP

1. Educate on the Science of Safety
2. Identify Defects (Staff Safety Assessment)
3. Senior Executive Partnership
4. Learn from Defects
5. Implement Teamwork & Communication Tools

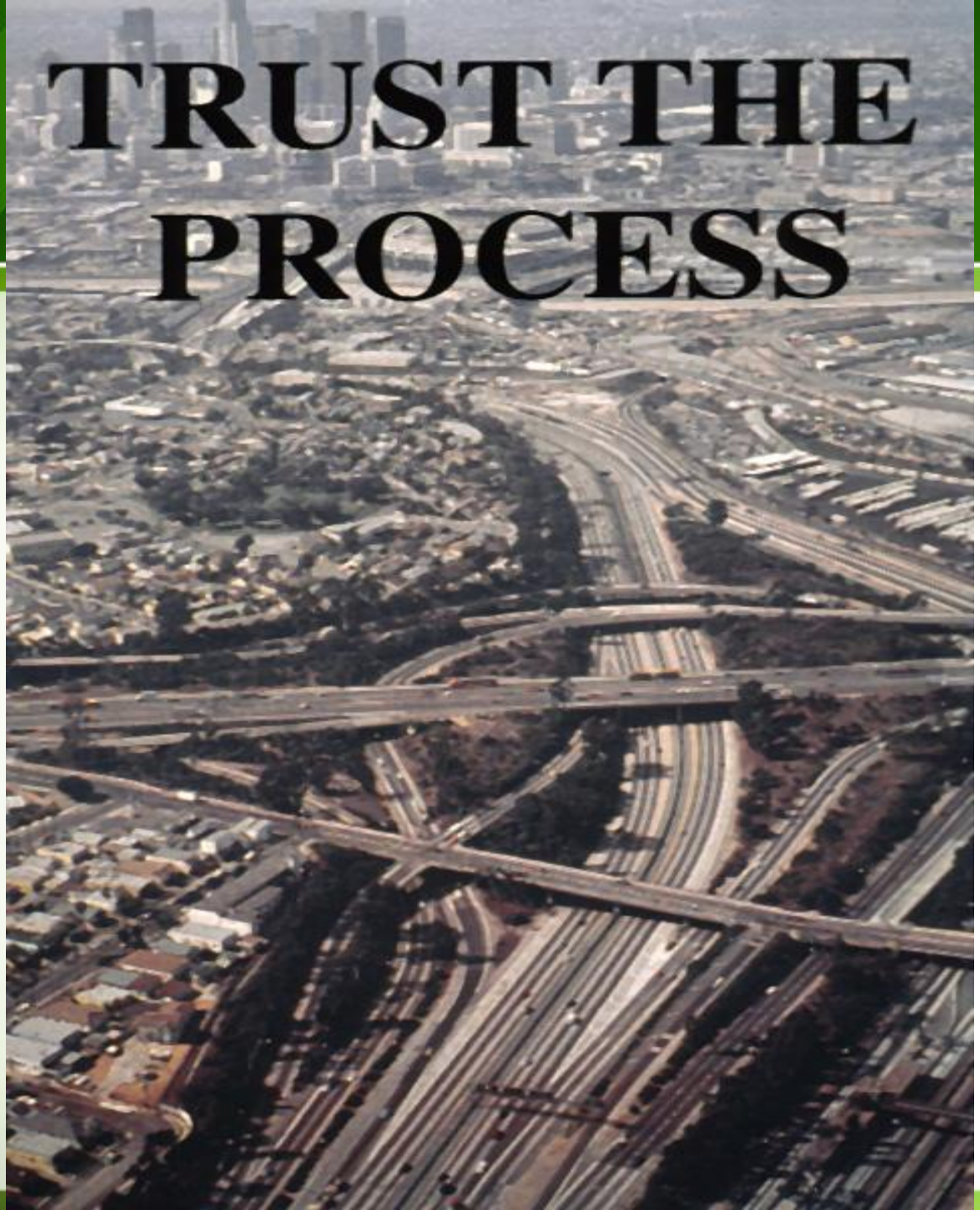
Technical

HAI/UTI

1. Insertion (assess need)
2. Maintenance
    a. Assessment & Site Care
3. Daily assessment for removal
4. Bathing

"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


TRUST THE
PROCESS

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%

50% HAI's Preventable

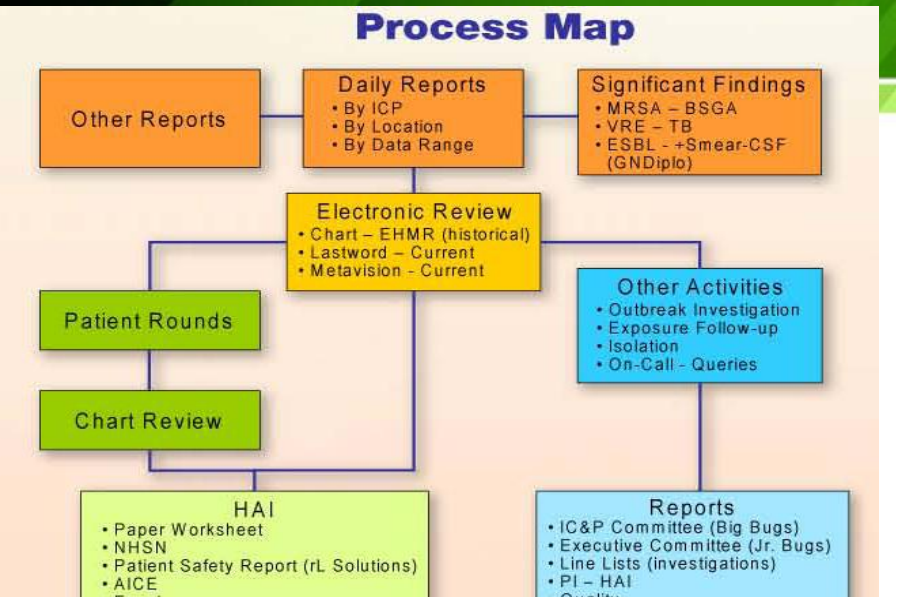
Per Case Basis

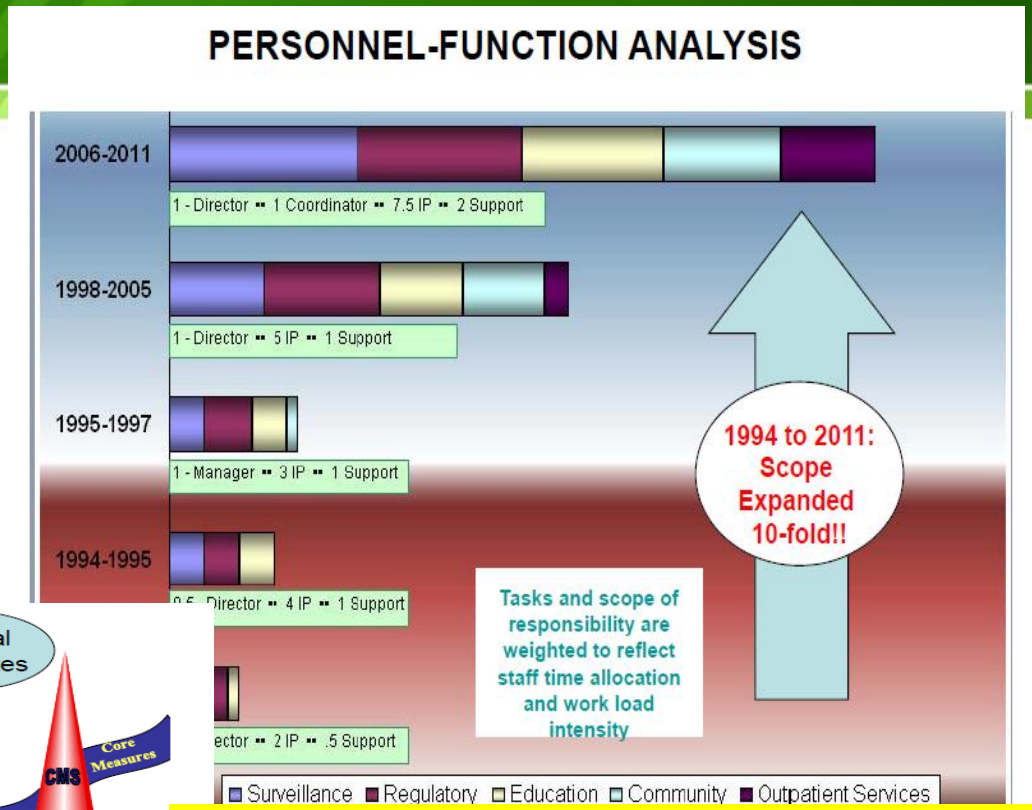
SSI	CLABSI	VAP	CAUTI	C-Diff
$20,785	$45,814	$40,144	$896	$11,285

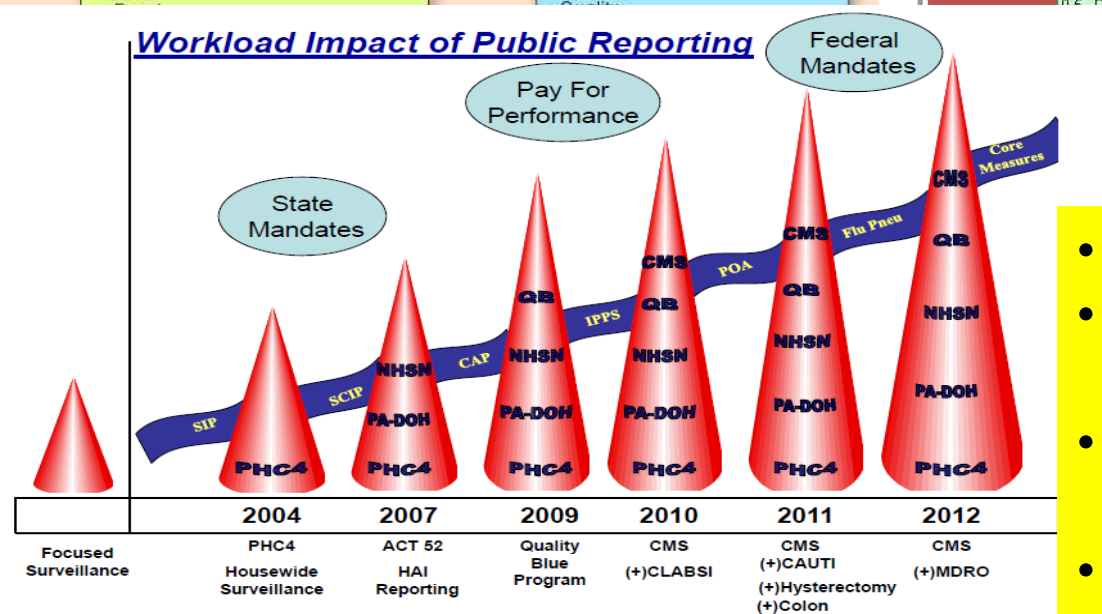
Zimlichman E, et al. JAMA Intern Med, 2013; 09/02/13 online

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

Be Courageous

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