

Year 2 Final WebEx:
Transition to Becoming a Learning Organization

***Infection Prevention in Arizona CAHs-
Managing Systems to Improve Quality***

***Year 2 Final WebEx:
Transition to Becoming a Learning
Organization***

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Information for Health Care Improvement



***REVIEW OF THE INFECTION
PREVENTION COLLABORATIVE
2009-2011***

Information for Health Care Improvement

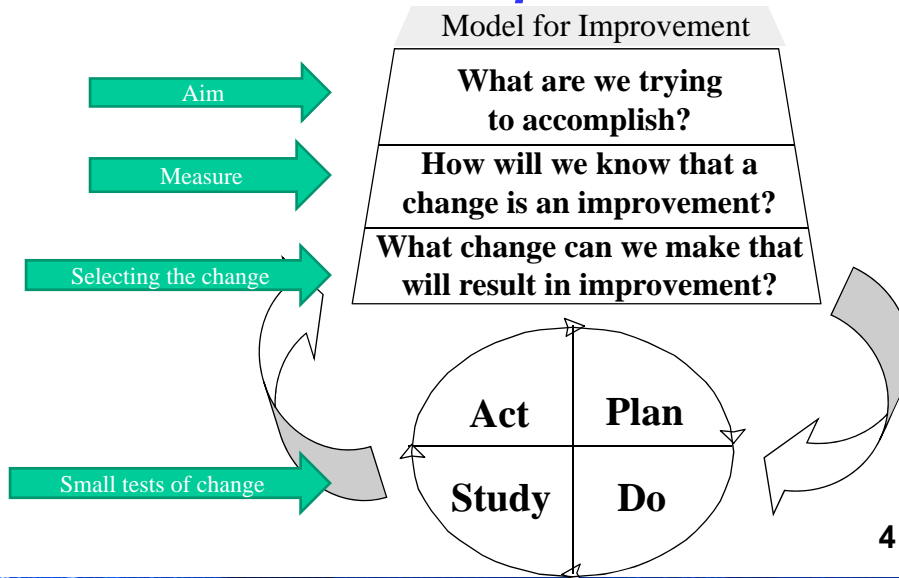


Plan, Do, Study, Act (PDSA) Improvement Model

&

Process Mapping

IHI Model for Improvement



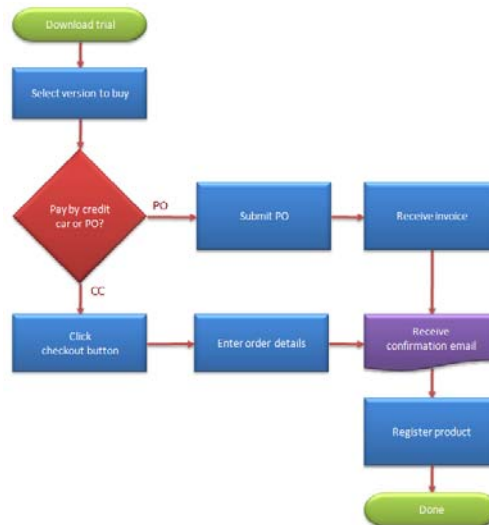
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Lessons Learned

- If at first you don't succeed, try, again.
- Look at others who perform the process well, both internally and externally.
- Borrow their ideas.
- Try again.
- Keep going.
- It's not the "best people" who succeed, it's the "best team's process"

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Process Map/Flow Diagram



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What Is the Value of a Process Map?

- Provides a picture of the process
- Shows complexity, rework, etc.
- Allows teams to agree on the process steps and examine which steps may impact the process performance
- Identifies parts of the process where data can be collected
- Serves as a training tool to understand the complete process

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Root Cause Analysis (RCA)

Flow Chart Analysis

- Analyze flow chart of actual process
- Analyze flow chart of best (ideal) process
- Compare both charts, looking for areas where they are different
- Most of the time, the stages where the differences occur are considered to be the problem areas (gaps or opportunities for improvement)
- Take steps to eliminate the differences and close the gaps

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Types of Error

- **Errors of commission**: doing something that has the potential to result in an undesirable outcome (doing something that shouldn't be done)
- **Errors of omission**: failing to do something that has the potential to prevent an undesirable outcome (not doing something that should be done)
- **Errors of execution**: doing something that should be done but doing it incorrectly

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Human Error: Poor Execution Unintentional Omission/Commission

- **Unintentionally** doing something that has the potential to result in an undesirable outcome
- **Unintentionally** failing to do something that has the potential to prevent an undesirable outcome
- Doing what should be done but **doing it incorrectly**

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Causes that Contribute to Undesirable Outcomes

- No policy/process in place
- Policy/process not followed
- Policy/process followed but insufficient
- Policy/process followed but execution deficient

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New View of Human Error

- Human error is not the cause of events, it is a symptom of deeper troubles in the system.
- Human error is not the conclusion of an investigation, it is the beginning.
- Events are the result of multiple causes.

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Analysis Should Include

- How did the incident happen?
- What factors contributed to the incident—at what level?
- Were policy/process intentionally disregarded?
- Were mitigating strategies for intervention identified prior to the event?

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Remember: The Goal Is to UNDERSTAND WHY

- The point of a human error investigation is to understand why people did what they did, not to judge them for what they did not do.
- We haven't fully understood an event if we don't see the actors' actions as *reasonable*.

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Guiding Principles & Leadership Engagement

Examples of Guiding Principles for Monitoring/Reporting Infections

Knowledge

- It is important for everyone to understand the purpose for monitoring/reporting infections.

Teamwork

- Appropriately reporting infections requires the cooperation of every person on the hospital staff and medical staff.

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Examples of Guiding Principles for Monitoring/Reporting Infections

Scope of surveillance

- For the purposes of infection monitoring and reporting, hospital staff includes all employees, contract staff, and volunteers working in patient care and non-patient care areas in the hospital and outpatient clinics.

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Signs of Leadership Engagement in Infection Monitoring/Reporting

- Setting the overall agenda for infection monitoring and reporting
- Establishing ‘hardwiring’ guiding principles
- Allocating resources
- Reviewing progress and results
- Discussing effectiveness of implemented changes
- Reviewing and discussing barriers
- Removing barriers

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Signs of Physician Champion Engagement in Infection Monitoring/Reporting

- Promoting changes within the medical staff
- Being thoroughly informed
- Providing information and guidance to other physicians

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Effective Aim Statements

- Answer the question, “What are we trying to accomplish?”
- Communicate the expectations
- Are time-specific
- Are measurable
- Define the specific population or populations affected
- Are clear and unambiguous
- Can be used in your elevator speech
- They aim BIG

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Sample Aim Statement for Infection Monitoring and Reporting

- By August 31, 2010, the infection control officer’s log of infections and communicable diseases will document 100% of the reportable incidents related to all hospital staff and patients, including infections up to 30 days post-operative for all inpatient and outpatient surgeries.

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Refining and Measuring Your Process

Understanding and Refining the Process

- Name of process
- Start point
- Extent of the process to be mapped (level of detail)
- Who cares about the process (stakeholders)
- Who is involved in delivering the process
- Activities that define the process
- End point
- Process output/product

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Aim Statement
By August 31, 2010, the infection control officer's log of infections and communicable diseases will document 100% of the reportable incidents related to all patients.

**COLORADO RIVER SERVICE UNIT
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Key Leverage Point(s)

- Intermediate points in the process at which monitoring will be easiest to accomplish and will give you most pertinent information as to whether your Aim is being accomplished.
- The key focal point(s) for designing interventions that will have maximum impact on improving the process.

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About Measures

- Measures can be used for learning.
- Measures can be used for judging.
- All measures have limitations, but the limitations do not negate their value.
- Measures are one voice of the system. Hearing the voice of the system gives us information on how to act within the system.
- Measures tell a story; goals give a reference point.

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Tips for Developing and Using QI Measures

- The key measures should clarify the Aim and make it tangible.
- Keep it simple; be careful about overdoing process measures.
- Seek usefulness, not perfection.
- Small samples over time should be used to determine if the process is improving.
- Collect data in segments at key leverage points in the process.

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Identifying and Overcoming Barriers

Tips for Developing an Effective Implementation Plan

- Clarify and communicate who does what by when and write it down
 - Make sure people know what they're supposed to do
 - And they know what others are supposed to do, too
- Make sure people know how to do what they are supposed to do
- Build in specific times to get input and feedback from those involved
- Use a proven approach manage the changes

Tips for Developing an Effective Data Monitoring Plan

- Who will complete the data collection tool for each data element ?
- How often and when will the data be collected?
- Who will receive the completed data collection tools?
- How will the data be analyzed/tallied and by whom?
- How will the data be aggregated and tracked?
- Who will the data results be reported to, how, and by whom?
- How often will the data results be shared?
- How will the data results be displayed?

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Take-Home Messages

- A well thought through Implementation Plan is one of the most important tools for successful execution of your process changes.
- A Data Monitoring Plan that uses concurrent data collection can save administrative time by eliminating after-the-fact-audits, and can save clinical time associated with rework.
- A formal announcement of the initiative by Executive Leadership can empower the QI team and facilitate cooperation for making the change successful.

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Analyzing Information for Decision Support

Questions for Meaningful Data*

- Should we stay the course or change direction?
- Is it too much or too little; too big or too small; too fast or too slow?
- Are we getting better or worse?
- Are the data stable enough that I can draw a conclusion from them, or are they jumping all over?
- Are things moving slow enough that I have time to think about this, or are they moving so fast that I have to make an emergency decision right now?

*"Using Simple Questions to Ensure Your Data are Providing Meaningful Answers for Your Board, Your Leadership, and You" Kenneth R. Rhode, Senior Consultant, The Greely Company, TGC@Greely.com, www.greely.com

Making the Simple Questions Work

- Set expectations for data you use
- Make all data you report useful
- Include conclusions in your data presentations

*"Using Simple Questions to Ensure Your Data are Providing Meaningful Answers for Your Board, Your Leadership, and You" Kenneth R. Rhode, Senior Consultant, The Greely Company, TGC@Greely.com, www.greely.com

Essential Components of an Effective QI report

- S- Results, context, this is what the data show
- B- Actions, this is what we had tried
- A- Conclusions, what made it work/not work
- R- Keep doing it, recommended small test of change
- Approval/feedback/ direction (set priority)

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Example of QI Report

Goal: By December 31, 2011 100% of abnormal lab tests on all hospitalized patients will be reported to the Infection Prevention Nurse (IPN) within 24 hours.

- Results for June 2011: 82% of abnormal lab tests were reported to the IPN within 24 hrs. This is the third month in a row that the rate has increased.
- Past actions: In March 2011 a process was implemented to clearly designate who is responsible for notifying the IPN of abnormal lab results.
- Conclusions from RCA: When a person knows s/he is responsible for notifying the IPN and receives the information regarding the abnormal lab result timely, the rate of timely notification of the IPN improves.
- Recommendations/Requests:
 - IP Team members be allotted 2 hrs. paid time in the first 2 weeks of July to review/revise the processes for designating who is responsible for notifying IPN of abnormal lab tests, how designated party is made aware of their designation, and how designated party obtains information regarding the abnormal lab tests.
 - The IP Team members be allotted 2 hrs. of paid time in the last 2 weeks of July to develop and roll out the implementation plan.

What Did You Do?

- Formed a team/developed AIM
- Developed charter/designated roles
- Engaged leadership and physicians
- Designed a process
- Designed a measure
- Measured your processes' performance
- Analyzed data and the process design
- Presented data/conclusions/recommended changes
- Redesigned your process
- Measured your new process, etc.

What BIG Changes Are Ahead?

- Since the 1997 the Balanced Budget Act has allowed CAHs to continue with cost-based reimbursement
- Now CMS is moving to overall transparency
- Mandatory public reporting of performance data is coming for CAHs
- Value Based Purchasing will be based on quality
- A “Learning Organization” culture with the ability to hardwire high performing systems will be essential

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Contact Information

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Over 1 million drug-related injuries occur every year in health care settings. The Institute of Medicine estimates that at least a quarter of these injuries are preventable.

To find out how to prevent medication errors, go to <http://www.hsag.com/drugsafety/>.



www.hsag.com

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