



Fast Facts



Infection Monitoring in Rural Hospitals—System and Practice: Learning Session 1

The *Infection Monitoring in Rural Hospitals—System and Practice* collaborative presented by Health Services Advisory Group, Inc. (HSAG) in collaboration with the Rural Hospital Flexibility Program at the Rural Health Office held its first learning session at the HSAG Phoenix office on **Thursday, November 19, 2009**.

Meeting Objectives

- Discuss the value of guiding principles and leadership engagement in setting system level Aims.
- Demonstrate how to plan and execute a plan-do-study-act (PDSA) cycle and a root cause analysis (RCA).
- Demonstrate how to develop a process flow chart using standardized flow chart techniques.

Meeting Highlights and “Take-Away” Messages:

- **The project is currently focused on improving the “infection monitoring and reporting process”.**
- Before you can improve a process, you need to know how it works.
- Process flow charting is indispensable in understanding how a process works and how it can be improved.
- Participants developed process flow charts (a.k.a. process maps) using standardized flow chart techniques.
- In order to know whether to continue improving a process, you need to have an Aim Statement.
- Leadership involvement is critical to setting a system level Aim that has the support necessary for success.
- It is essential to have a systematic method to guide process improvement and quality improvement efforts.
- The FOCUS framework and PDSA method repeatedly demonstrate that ongoing improvement is possible.
 - **F**ind a process to improve
 - **O**rganize an effort to work on improvement
 - **C**larify current knowledge of the process
 - **U**nderstand process variation and capability
 - **S**elect a strategy for continued improvement
- Participants gained “hands-on” practice in the PDSA method (tennis ball simulation) which included:
 - Forming teams and designating team member roles
 - Brainstorming and designing a process
 - Measuring its performance and benchmarking its performance
 - Analyzing the process design and redesigning the process
 - Measuring the new process, etc.
- Participants completed a Root Cause Analysis (plane crash video) and identified errors of commission, omission, and execution related to human factors, human errors, and communication issues.

Next Steps **(to be completed by Thursday, January 14, 2010)**

- Hospital team leaders will discuss options and affirm with their CEOs a process they want to focus on for the duration of this project. If the hospital opts to change the process they want to focus on, the newly selected process must involve the team leaders (and ideally the members) already assigned to the project.
- Hospital teams will create a flow chart of the process (as it currently exists) that the project will focus on.
- Hospital teams will develop a project ‘Aim Statement’ with active participation from hospital leadership.
- HSAG staff will call hospital team leaders to provide technical assistance with these Next Steps.
- The next learning session will be held at the HSAG Phoenix office on Thursday, January 21, 2010.