HAI PREVENTION: Outside the Fishbowl Looking In

03.25.11

34th Annual Conference

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HAI ↓ STRATEGY: **Anonymous Q&A “Style” Benefits**

• **THANK YOU**: Christine Nightingale, RN, BSN, CIC: Billings Clinic MT
  
  – April 2009 Montana APIC Annual Conference  
  – No Reference  
  – Learned in 1987 at a State HIV/AIDS Educational Seminal

• Excellent Teaching “Fishbowl Perspective” Strategy
  
  – The Anonymous Approach ↓ Defensiveness of Topic  
  – Promotes Freedom to Explore Options  
  – Might Make You “Wear the other Shoe”
OBJECTIVES

• Discuss progression of IP&C as a healthcare resource to decrease HAI’s

• Explain HAI prevention from the perspective and the C-Suite

• Describe two strategies to assist non-Infection Preventionists to internalize the urgency of HAI prevention.
Progression of IP&C

• AJIC 2000¹ “Interventional Epidemiology” w/Review Prior Era(s)
  – 1960’s Exploration
  – 1970’s Expansion
  – 1980’s Reaction & Response
  – 1990’s Regulation
  – 2000’s Interventional Epidemiology
    • Need to **Demonstrate Value** a Constant Truth & Challenge
Key Publications & Advancements

• AJIC 2005\textsuperscript{3} The Economic Impact of Infection Control: Making the Business Case for Increased Infection Control Resources

• AJIC 2008\textsuperscript{2} Building the IP System of Tomorrow: Proceedings of the 2007 APIC Futures Summit
  – Landmark Article of Framework for Evaluating Economic Impact HAI’s
  – Practical Tips to Augment Do’s/Don’t when Requesting $ Administrator

• How Much Does it Cost Now? \textsuperscript{4}
Progress: IP&C Resource Needs

• AJIC 2009\(^5\) Staffing and Structure of IP&C Programs
  – 1\(^{st}\) Study to Provide Comprehensive Description “Snapshot”
  – Survey Sent to 441 NHSN Facilities: 66% Response Rate
  – Higher Staffing in Smaller Facilities (\(p < .0001\))
  – Median Staffing 1 Infection Preventionist (IP) per 167 beds

• APIC Infection Prevention Program Evaluation Tool (released April 2010)
  – Press Release\(^6\)
  – Accompanying Referenced White Paper\(^7\)
  – Free to APIC Membership to Download\(^8\)
WHAT DOES THIS REALLY MEAN TO IP&C .... AND HOW WE OPERATE?
The 7 Measures of Success

-- Written for Non-Profits Yet Can Apply Universally --

• **COMMITMENT TO PURPOSE**
  1) A Customer Service Culture
  2) Alignment of Products and Services with Mission

• **COMMITMENT TO ANALYSIS AND FEEDBACK**
  3) Data-Driven Strategies
  4) Dialogue and Engagement
  5) CEO as Broker of Ideas

• **COMMITMENT TO ACTION**
  6) Organizational Adaptability
  7) Alliance Building

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Being Obsessively Data Driven

+ The Creativity & Discipline to Act on Data
Uncomfortable Idea Zone ... **DISCLAIMER**

• Do Not Kill the Messenger
  – Just Wanting to “LOOK” at HAI Aspects Differently
  – Do Not Necessarily “AGREE” with Everything Presented
    • Up to you to determine what is “REAL” for your Facility
  – Shall We View from Inside-Out of the Fishbowl?
The Forgotten Reality in HC

• Expanding What We Know About Off-Peak Mortality in Hospitals
  – 64% “Off Peak” Patient Care is Delivered
    • Nights & Weekends .... “Off Hours”
      – Limited Ancillary Services
      – Fewer Support Staff
      – Decreased Direct Supervision
      – Strained Communications (on-call MD and/or leadership)

• Ask Yourself as an Infection Preventionist:
  – With Only 36% of Bedside Care “Optimal” Environment
  – What Happens During Off Hours & HAI Prevention?
So How Do We View the Fishbowl? 
Inside Out ... Outside In

• Articles & Teachings of Ken Segel, MBA 10-11

• First time: APIC Future’s Summit 2004 → HAI Epidemic in USA

• Remember Martin Luther King ....

“Our lives begin to end the day we become silent about things that matter”
The Altered ?! View & Perspective

• Despite Public Grassroots Demands Reporting → Federal/State HAI’s
  – IP&C only marginally closer to center of healthcare leadership
    • Initial IP&C business attempts ‘shallow’ a call for IP&C resources
    • Transparently linked to ‘preserving’ our own professional budgets

• IP’s a Victim? .... Student? ... Of the Current Healthcare System
  – Leadership and IP&C Staff Trained .... Trapped? ... In Silo Approach
    • Silo: Purpose, Specialty, Expertise
    • Silo: Departmentalization
    • Silo: Multiple Layers within each Silo (Chain of Command)
Moral Clarity & HAI’s

– Traditional Silo Method Does not Blend Well with Moral Clarity

• If it is OK to accept HAI’s

• Who is it OK to give a HAI to?

• Can most healthcare professional internalize Moral Clarity?
Contrast in Thinking: Any Safety Topic

TRADITIONAL APPROACH

Reduce Cost

OR

Increase Quality

OR

Reduce Lead Time

Results generally come with tradeoffs

VALUE CAPTURE APPROACH

Safety/Quality

(↑ 90–100% improvement possible)

Great processes = great results in all 3 dimensions of performance

Cost

(↓ 30–50% improvement possible)

Lead Time

(↓ = waiting eliminated)

Results achieved simultaneously

From Prevention strategist Spring 2010: K.Segel page 44
HC Community “NARROW”

• **Great Organizations** have Core of Strategy
  
  Of *Not* Separating Finance from Safety Improvements

• IP&C Struggles Despite ↑ Visibility of Public Reporting
  – Generalized Cost vs. Revenue Comparisons
  – Great “Cost/Staffing” IP&C Tools, yet
  – Limited Impact in Business Model

• Ask CFO for Cost Projection Help?

**REACTION & RESPONSE?**
EQUAL = Time, Emphasis, $$

• No Separation of Finance & Quality

• Process “STABLE” Enough to Produce Excellent Outcomes via
  -- Less Resources Overall
  -- Secondary to
    -- Less Material Waste
    -- Less Wasted Human Effort
Move Away From ...

- The Dreaded “Work Around”
- Situational Excellence
REALITY: What Blocks Success?

• **C-Suite**: Reimbursement Systems Undermine Willingness and/or Ability
  – Keep clear FOCUS on positive safety outcomes → Reactive
  – Convoluted payment systems …. New National Healthcare?!

• **C-Suite & IP**: Silo (Job Shop) Structure for Patient Care
  – “Grew-Up” as ideal approach to success
  – Functional Expertise without cross process focus
  – Can’t see front-line patient care (Organized Zoo?)

• **CEO**: Held Accountable to Hospital Board and “Corporate” for
  – A pattern of losing money (being in ‘the red’)
  – Poor relations with Medical Staff
  – Keep the beds full
What Does This Mean?

• C-Suite: Taught to “Think Finances First”
  – An unavoidable reality

• CEO **fired** if does not ‘fit the bill’
  – HAI Prevention is competing with this harsh reality
  – How does this manifest in the healthcare safety culture?
Consider **C-Suite** Frame of Reference

• **WIN:WIN** → **QUICK, VISABLE, “EASY”, and FAST** → **INSTANT Success**
  – Investments in new healthcare services
  – Capitol investments of old services and equipment
  – Constituents Obviously Happy

  **VERSUS**

• **MIGHT** WIN: → **SLOW, HIDDEN, “HARD”, and PAINFUL** → **Success**
  – Investments not rapidly obvious (not quick fix)
  – Slow tension accompanies gradual changes of culture
  – Hardwired operational improvements hidden
  – Constituents Not Universally “Happy”
C-SUITE MOVING FORWARD

• Help Blast Away “Silo Thinking” for Patient Safety & HAI Prevention

• Stop Using Old Silo Approaches
  – Giving an even more perfect report in a committee setting
  – Presenting an even more impassioned speech in the same meetings

• Promote Facilitated Situational Observations at the bedside
  – Hope Leadership Develop EYES TO SEE
    • Where value is lost
    • Where value can be created
    • To Secure a Win-Win .... Help see how this is a Big Bang for Buck
IMPACT OBSERVATIONS

• Silently Shadow Bedside Staff (Remember HIPAA)

• No Interruption of Bedside Flow of Care
  – Let leadership *experience* the ‘work around(s)’ yet ....
  – Observe the exceptional professional expertise and compassion
  – Why there is no *time* to unlock wasted resources to improve
  – See Together … Know Together … Do Together

• Leadership Can Be More Prone to:
  – Unlock frontline FTE’s away from the bedside to problem-solve
  – Focus ideas and approaches to decrease HAI’s
  – Understand the *concept* of Zero HAI’s → Culture not a Number
Impact Observations Not Leadership Rounds

**LEADERSHIP ROUNDING**

- Provide Valuable Chance to Interact with Staff
- Primary Focus: Exchange of Talking & Interaction
- Staff “Hand-Off” Problems for Leadership to Solve
- Traditional Silo Approach

**IMPACT OBSERVATIONS**

- Provide Opportunity to Experience & Understand
- Primary Focus: Facilitated Q&A Process at Bedside
- Staff Are Not Interrupted & Own the “Solve” Success
- Bedside Emphasis Approach
HAI’s: Why So Painful & Slow

- Does not fit **Big Bang for Your Buck** Model

- Difficult to Stabilize Bedside Process → Take CLABSI Dressing Changes
  - A. Supplies Available?
  - B. Supplies Easily Accessible?
  - C. If A & B true, then,
  - D. Are the bedside staff doing the same thing in same sequence?

- What should bedside CLABSI dressing change look like?
In An **Almost** Perfect World:

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<th>Don Clean Gloves</th>
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From *Prevention strategist* Spring 2010: K.Segel page 46
What Does REALITY Look Like?

From Prevention strategist Spring 2010: K.Segel page 46
MOSTLY “FREE” FIX

• No New Supplies to Purchase
• No New Inservice Education for New Supplies Purchased
• Use Equipment On-Hand
• Have Leadership Guidance Only

BEDSIDE STAFF “FREE”
To ASSESS & IMPROVE
THEMSELVES
Moving to “Controlled” Process

• Scary yet Innovative Thoughts for Nursing Staff

• Be Open and Willing to Participate for Patient Safety Effort:
  – Nurses observe each other?
  – Put “blocks” in place and/or number pre-printed sheet?
  – Will observe 1\textsuperscript{st} hand variations and steps in the process
  – Will observe “shabbily done” work at the bedside?
  – Bedside professionals Stabilize the Process?
OWNERS STABILIZE

• HAI’s Can be Decreased by the People Who DO THE WORK

• Stabilize The Process = Stabilize The Outcome
  – The IHI Bundle(s) = Decreased CLABSI and VAP
  – SCIP Measures = Decreased SSI’s
  – Best to Show with “YOUR” Own Healthcare Specific Data

• Variation in Process = Variations in Outcomes

• Doing the Right Thing is Most Often the EASY Thing
  – Once Assessed, Placed, and Practiced
WHAT ABOUT THE Infection Preventionists FISHBOWL ?!
The IP’s Fishbowl

• Rates per 1000 Days of Something
  – Seen as ‘nagging’ versus ‘partner’ approach

• National and/or Internal Benchmarks
  – Compared to Rates per 1000 Days of Something
  – Process Control Charts

• Hide the HAI Reality Behind Rates & Benchmarks
  – Can’t See or Feel the Individual Pain and Suffering
  – Keeping it “Sanitized” by Making the “Person” Invisible

• Old Retrospective Data by Month, Quarters, Annual
Uncharted IP Fishbowl Waters?

• Help Bedside Staff Develop “Eyes to See”
  – Include Number of Patient’s Infected
    • Include Numerator and Denominator with Rates and Percents
    • Include a Line-Listing of Patient’s Infected
      – Social History? (Family, Job, Extended Length of Stay)

  – Also Provide Prospective HAI Data
    • Check Daily? Every 48-72 Hours for CLABSI or VAP?
    • Provide “Immediate” Feedback to bedside and CEO of HAI?
    • Bedside Staff to Perform and Report ‘mini RCA’ → Accountability
      – Two Examples Given
OBJECTIVES

• Discuss progression of IP&C as a healthcare resource to decrease HAI’s

• Explain HAI prevention from the perspective and the C-Suite

• Describe two strategies to assist non-Infection Preventionists to internalize the urgency of HAI prevention.
Dodd M. Day from PHHS
“Construction: Stirring Up Trouble”
APIC-DFW August 2010

IF YOU PERMIT IT ... 

YOU PROMOTE IT
QUESTIONS?

• Thank You

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