


Taking Quality to the Next Level

Prov. Peter Pronovost, Johns Hopkins University

Sponsored by the World Health Organization Patient Safety Agency – Clean Care is SAFER Care




**Taking Quality to the Next Level:
Together We Achieve**

Peter Pronovost, MD, PhD, FCCM
Johns Hopkins University

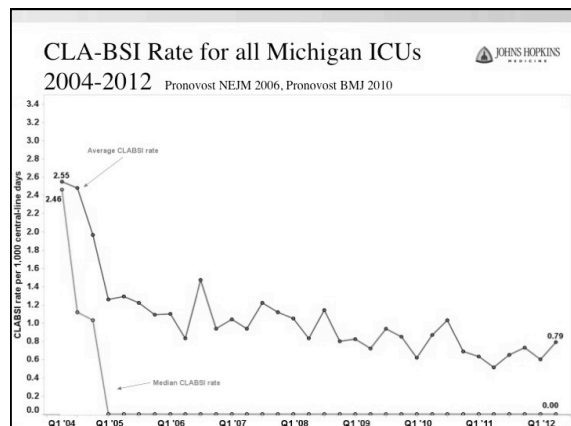
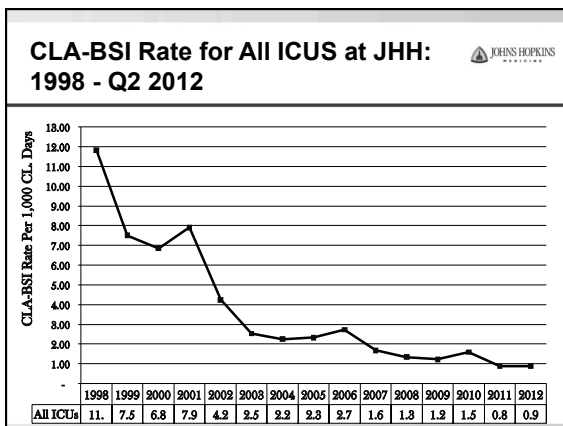
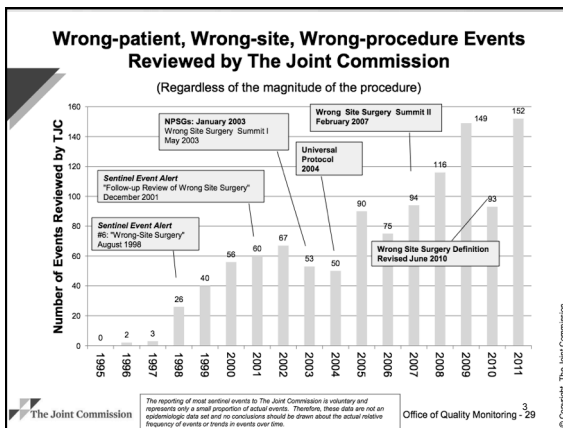
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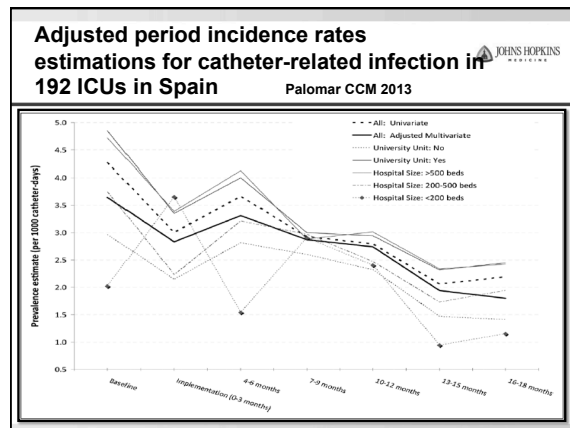
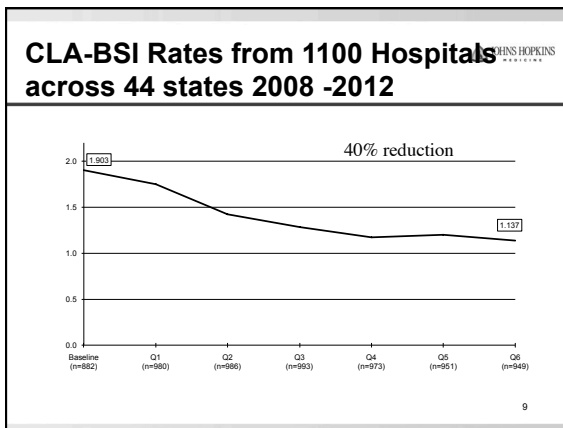
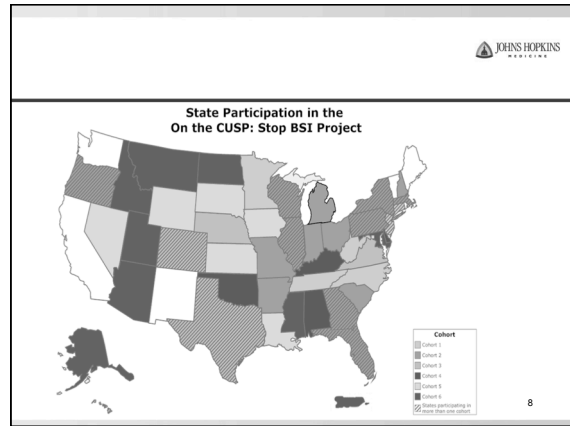
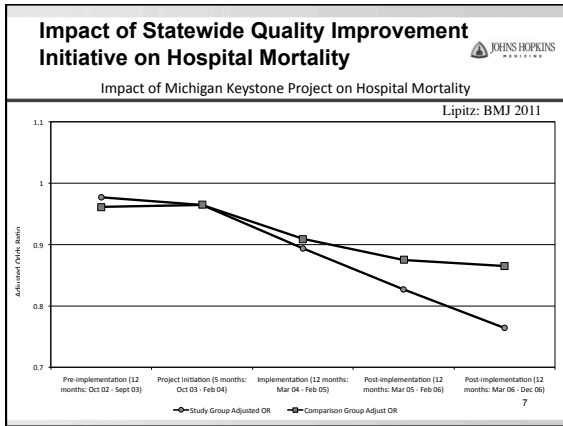


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Improving Care

CUSP	Translating Evidence into Practice (TRiP)
<ol style="list-style-type: none"> Educate staff on science of safety Identify defects Assign executive to adopt unit Learn from one defect per quarter Implement teamwork tools 	<ol style="list-style-type: none"> Summarize the evidence in a checklist. <ul style="list-style-type: none"> Wash your hand, clean skin with chlorhexidine, avoid femoral site, use barrier precautions, ask daily if you need the catheter Identify local barriers to implementation Measure performance Ensure all patients get the evidence <ul style="list-style-type: none"> Engage Educate Execute Evaluate

www.hopkinsmedicine.org/armstronginstitute

Peer to Peer Review Getting to 0 CLABSI

- CEO commits to 0
- ICU leaders accountable, know rates, commit to 0
- ICU makes it easy to comply with checklist
- ICU empowers nurses to ensure compliance
- ICU reviews every infection as a defect
- ICU standardizes, audits, and improves catheter maintenance
- ICU posts and discuss infection rates weeks without an infection

<http://www.modernhealthcare.com/article/20110725/SUPPLEMENT/307259972-1>

Pronovost BMJQS 2012

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Explaining the Keystone project

Clinical community, led by clinicians

- Informed by science, guided by measures
- Adaptable, evolved over time
- Intrinsic motivation
 - peer pressure
 - social network
 - social problem capable of being solved
 - judicious use of harder edges
- A culture change intervention



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Lesson 1 & Lesson 2

A national program should be sufficiently ripe before a national roll out

- Interventions should be able to demonstrate harm reduction and a standardized methodology must be used to measure it
- There needs to be clear theory behind the intervention
- Effective trials demonstrating generalizability allows for success

A national program should have a clear chain of accountability, with a sufficient infrastructure at each level to support the work

- Fractal infrastructure at the national, state, health system, hospital, unit, and individual clinician levels provides an effective structure
- Each level should allow for goals and measures, quality management infrastructure, skilled staff with protected time and resources, accountability for achieving results, and opportunities to network horizontally

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Lesson 3 & Lesson 4

A national program should align the work of all stakeholders around a common standard measure

- A standard measure that is feasible by stakeholders at all levels of the program, and that clinicians believe is valid and useful in tracking performance unifies a program
- Real-time access to data with monthly reports allowed the unit's to gauge performance
- National programs should collect data that can be aggregated from units to higher levels, ultimately making national estimates of their impact

A national program should summarize the evidence and encourage local clinicians and administrators to modify the intervention to fit their culture and needs

- Interventions must be developed with rather than over clinicians
- Each state and hospital used local wisdom to implement the program
- Prevention practices were standardized, but implementation of the practices was locally modified
- Without this, there is a higher chance an intervention will fail. Dissemination is an adaptive rather than a dictated process, with participating teams co-creating the intervention

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Lesson 5 & Lesson 6

A national program needs an equal focus on technical and adaptive work

- The CUSP intervention addressed issues, such as safety climate, clinician engagement, transdisciplinary interactions, and sense of community
- Teams were encouraged to improve teamwork, and identify and mitigate hazards
- The technical work involved the quantitative components such as: the science for how to measure and reduce CLABSI

A national program should start with the goal and work backwards, pulling as many levers as possible

- Multifaceted interventions, at the national, state, and local levels were used to eliminating infections, with the ability to evaluate the impact of any single intervention or component to reduce CLABSI rates
- The team developed additional checklists to provide CEOs, hospital boards, and infection preventionists with tasks to support zero infections

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Lesson 7 & Lesson 8

Clinicians must believe the harm is an important problem capable of being improved

- Change is possible when clinicians see that the harm is an important problem that can be improved
- Encourage the sharing of experiences with evidence-based interventions and the success of the team
- Face-to-face meetings were designed to maximize intrinsic motivation and included problem solving & community building

Data should facilitate learning rather than blaming

- Data can be used to motivate change
- Report data back to front line staff to facilitate learning and provide feedback
- Highly effective when clinicians believe the data are valid and when evidence is strong that improvement is possible

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Advancing the Science


- Peer to Peer Review
 - Harm, area, program
- Quality Management Infrastructure
 - Link beside to board
- Systems approach
 - Eliminate all harms not just one

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Harms to be eliminated – Associated Tasks 


Harms	CLABSI
Delirium	Hand washing
Acquired Physical Impairment	Chlorhexidine
Ventilator associated infections and harms	Full Barrier Precautions
DVT-PE	Avoid femoral site
CLABSI	Remove Unnecessary line
Loss of Respect and Dignity	Use of checklist
Failure to provide care consistent with patient goals	Availability of cart

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Harms to be eliminated – Associated Tasks 


Harms	DELIRIUM
Delirium	CAM ICU assessments
Acquired Physical Impairment	Automated screening
Ventilator associated infections and harms	Modifiable factors
DVT-PE	Non-pharmacologic interventions
CLABSI	Sedation management
Loss of Respect and Dignity	Pain Scores
Failure to provide care consistent with patient goals	Family education

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Harms to be eliminated – Associated Tasks 


Harms	Acquired Physical Impairment
Delirium	Early ambulation
Acquired Physical Impairment	Adjunctive physical therapy
Ventilator associated infections and harms	Pharmacologic management
DVT-PE	Prospective testing
CLABSI	Family engagement
Loss of Respect and Dignity	Transition of care planning
Failure to provide care consistent with patient goals	

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Harms to be eliminated – Associated Tasks 


Harms	Ventilator Harm
Delirium	Daily sedation vacation (SAT)
Acquired Physical Impairment	Daily spontaneous breathing trials (SBT)
Ventilator associated infections and harms	Automated ventilator management
DVT-PE	Lung Protective Ventilation for ALI
CLABSI	Low Volume Ventilation if not ALI
Loss of Respect and Dignity	
Failure to provide care consistent with patient goals	

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Harms to be eliminated – Associated Tasks 

Harms	VAP
Delirium	Head of Bed Elevation (HOB) (≥ 30 degrees).
Acquired Physical Impairment	Spontaneous Awakening and Breathing Trials (SAT & SBT)
Ventilator associated infections and harms	Oral Care
DVT-PE	Oral Care with Chlorhexidine
CLABSI	Subglottic Suctioning ETTs
Loss of Respect and Dignity	
Failure to provide care consistent with patient goals	

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Harms to be eliminated – Associated Tasks 

Harms	DVT-PE
Delirium	Initial VTE risk stratification for all ICU patients
Acquired Physical Impairment	Computerized clinical decision support (CDS) tool to aid ordering of best-practice VTE prophylaxis
Ventilator associated infections and harms	Ongoing risk re-stratification
DVT-PE	Reminders when contraindications change to prompt addition of pharmacologic prophylaxis
CLABSI	Ultrasound screening of appropriate patients
Loss of Respect and Dignity	Prevent missed prophylaxis doses
Failure to provide care consistent with patient goals	Optimal Mechanical Prophylaxis Use (Sequential Compression Device [SCD] and compression stockings [TEDS])

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Harms to be eliminated – Associated Tasks

Harms	Loss of Respect and Dignity
Delirium	Interpersonal communication
Acquired Physical Impairment	Scheduling
Ventilator associated infections and harms	Education
DVT-PE	Goals alignment
CLABSI	Access to care team
Loss of Respect and Dignity	Inclusion
Failure to provide care consistent with patient goals	Continuity

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Harms to be eliminated – Associated Tasks

Harms	Failure to provide care consistent with patient goals
Delirium	Family meetings
Acquired Physical Impairment	Advanced directives
Ventilator associated infections and harms	All teams meetings
DVT-PE	Ethics engagement
CLABSI	Palliative Care
Loss of Respect and Dignity	
Failure to provide care consistent with patient goals	

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Do you believe

2013 WHO Teleclass Schedule

Clean Care is Safer Care

February 6
Improving the Patient Safety Culture as a Successful Component of Infection Control Strategies, Dr. B. Allegranzi

March 6
Patient Participation in Hand Hygiene Promotion and Improvement, Dr. Y. Longtin & Dr. M. McGuckin

April 9
Innovation and New Indicators in Hand Hygiene Monitoring, Prof. J. Boyce

May 6
Special Lecture for 5 May, Prof. D. Pittet

July 10
Risk Assessment and Priority Setting in Infection Control in Low to Middle Income Countries, Prof. N. Damani,

August 7
Decontamination of High-Touch Environmental Surfaces in Healthcare: A Critical Look at Current Practices and Newer Approaches, Prof. S. Sattar

September 3
Preventing Central Line-Associated Bloodstream Infections: The Matching Michigan Approach Applied in the USA and Other Countries, Prof. P. Pronovost

October 9
Implementing Infection Control Through a Patient Safety Partnership Approach in Africa, U. Storr

November 11
Antimicrobial Resistance Issues Worldwide and the WHO Approach to Combat it, Dr. C. Pessoa da Silva

December 4
Control of Multi-Drug Resistant Organisms in the Nursing Home Setting, Prof. A. Voss

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www.who.int/gpsc/en

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