I have to admit to you that what they told me I was presenting today was a CDC update. Then when I saw that I had so many faction practitioners in the room I thought, why are you doing a CDC update. I looked at what Tonya wanted vs. what I was told we were doing so I made a couple modifications. Tonya is going to make these slides available as an electronic attachment for anybody that wants them.

Needless to say, for those of you, especially the last three that were talking, we’ve made great strides in talking about…

→ Can we get to zero?
→ What does it encompass to get there?
→ How does the program actually play a role in getting us to zero?

So I thought, let me throw together some other slides that I think would be more pertinent to what you’re doing. How many of you have not worked on the program, this is all new to you and you’re just coming out for a day of learning? So I have a couple of people that are new.

What is Comprehensive Patient Safety Program? We believe in reducing the number of steps to improve not only the likelihood that we’ll have frontline providers actually implement, because the more steps it has it’s like giving a nurse another piece of paper, we don’t really want another piece of paper. The more steps we have to go through the less we’re going to like it.

This started out as an eight-step intervention and ended up being a five-step intervention. The nice thing about it is, as the last speaker from Mayo, Sarah mentioned. The important part about this is we can do all the top down that we would like, but it’s really the bottom up that gets a lot of the work done. So initiatives that are federally mandated, we’re going to get some response, even the national program is going to get some response. Until you have frontline providers that actually begin to take charge and ownership do we really see that that not only gets us the biggest bang for the buck, but brings about the biggest culture change that we see as well.

I talked earlier about expanding and embedding and really, you can use this in any unit. We have this currently in most of our general in-patient as well as our ICU and OR wards and even some of our out-patient centers, so we can do it.

The National BSI Project was set up to do two things:

1. **Inaudible**, which we’ve all heard about.
   - Removing unnecessary lines,
   - Wash our hands prior to procedure,
   - Use the maximum barrier precautions,
   - Even if you don’t have hair put on that cap,
   - Use the full barrier drape,
   - Clean the skin with chlorhexidine and actually use it the appropriate way.
Sarah who was just talking, I understand your pain. I’ve worked with cardiac surgeons forever and I had to get the guy that supplies us with chlorhexidine to show them what appropriate skin prep was because they weren’t letting it dry and were wiping it off with sterile towels. It’s no good. I said to them it’s not just chlorhexidine, it’s the Betadine; isopropyl and the Betadine wash and we still have to let all of them dry to be effective.

So it’s nothing new, they should have always been doing it, but they didn’t buy it. So the chlorhexidine rep brought it out. He brought all the different colors, the yellow, the blue, the red. Blue is not good for a cardiac population, because you just don’t look so great. I would say with Betadine, I can see where it goes. I say okay, well this one is orange, this one is red. He can see it just as well. I still have a hard time with compliance with my cardiac surgeons. They’re still my most difficult person and my biggest dissenter.

The other thing was, in Michigan we implemented classy vap and cups and educated the staff on the signs of safety again it was eight points with that and that’s looking at error being systems-based rather than looking at just culture. So a person may be involved, but we play a little role. Instead of saying you did that or Michelle this is your fault because you didn’t do something, we could take Michelle out of the mix, put any other provider in there and the event is still going to happen. We’re just a small percentage of why this happened.

It’s also about, when you take the punitive nature out of it, you’re saying this could happen to anybody and it’s really more of an issue of knowledge, deficit and maybe initial education, rather than somebody was incompetent or they weren’t paying attention. We assign the executives to adopt a unit, that’s been in play, they’ve been using that at Harvard for over 10 years now. We turned it into executive adopt a unit because we saw the executives that came to the floor at least eight times within a year had bigger culture change than those units that didn’t have the executive consistently come by.

Learn from one defect recorder, as Sarah mentioned, that is really the big bang for the buck. Your defect doesn’t have to have anything to do with inaudible, not one thing. So you might have no infection and say I don’t have any defects to investigate. It all comes from your staff safety. So that group that knows that there are men with really large feet who are falling, at least three per month they need a different slipper. The other thing infection rates within our neuro orthopedic OR. All the housekeepers really wanted was a Swiffer Wet Jet, because they said those little bone fragments were hard to get up with a general mop. They wanted something that cleaned and sucked it up at the same time.

So we got them and then here comes the VP of Johns Hopkins Medicine carrying in three Swiffers. They were the happiest women on earth and not only that, we notice the ORs were cleaner. It’s about those kinds of defects, not necessarily to your BSI rate but about defects in general. How do you think your next patient is going to be harmed and there are all kinds of ways?

I said do we really want to share that? What are they getting? I noticed that my nursing students were the only people that actually rinsed them out, somebody that needed one had one of their very own, rather than one unit. So we weren’t giving somebody that’s already hypotensive and orthostatic with a low heart rate, giving them a little bit of the beta blocker that we’re saving for the next cardiac patient.

Implementing the team report, which she talked about as well and there are numerous team reports, for the OR, the floor and for the ICU and all very important. The two separate components inaudible and altogether they’re what makes this program work. It’s the Cusp Program that we feel either one of these can be picked up and moved out, which is where we talked about embedding and expanding. The goal between the Cusp Program is to improve error, reinforce good inaudible, better communication and teamwork. If Sarah said that once she said it at least three or four times and that’s what’s really important.

Enhanced coordination of care, we have a lot of flaws in how we deliver care patient flow with that. I can tell you when I was a nurse how many times they’d call me and say, if you don’t move it, I’ve got Mr. So and So, he’s off the bypass but is on a vent and for every minute you delay it’s $1000 on the OR, you’re wasting my money and my time. So it’s about patient flow as well.
Address overall patient safety—again, from the front lines perspective, also, from the nurse manager. I have them here and they were telling me, you know what David, I started to identify those things I saw more than once a month or if it had catastrophic outcome. I worked with my front line staff to fix those first. Then we chose all the low lying fruit, all the things we could do with little cost and effort on our part and the front line staff actually looked forward to their Cusp meetings and were doing it.

The BSI reduction protocol we’ve all talked about was just to do that, reduce [inaudible].

Science of safety— I can’t say enough about how important this is. We’ve made this mandatory for all of our physicians and nurses as part of the Cusp Program, because you do see things as systems based error, so that punitive nature when I was in nursing, before I got my Masters Degree I did a lot of moonlighting. I worked in SICU but I moonlighted in the cardiac SICU and policies and procedures were so different. The opportunity for making mistakes was great and a lot of people did that because we had on floating in the hospital and they might say oh, we don’t need you today you can have a vacation day. However, we were money hungry and nurses weren’t pay very well so we would ask if they needed anybody and we’d float to the next unit.

Were they set up the same way? No. The potential for error was different. Even how they shot cardiac outputs were very different. In the NICU they had something called a MICU bridge and they used the IV fluid, so you took the IV fluid out of the [inaudible], potentials for error everywhere, it was amazing. The fact that we were in the same hospital but we didn’t have unified policies and procedures was one of the first things that we fixed.

Create independent checks for key processes— I can’t emphasize this more and I love that about the Science of Safety. For those of you that are nurses, we would do insulin checks. So I’d say okay I’m giving six units of regular insulin, because my patients on [inaudible]. So here I am I’m coming up and walking, hi Sally, here’s my insulin, I have my insulin and then I’d have my [inaudible] right here. She’d say yes you have six units, but did she really know the case of the regular in put? Not really. They have all the information for it to be a true independent checklist. She would have had to see what [inaudible] 305. Then she would have needed to see the order. Okay, prescribe [inaudible] he gets six units of regular insulin and then she would have had to see that needle and syringe in the vial.

It never happened. It just now began to happen. Learn from our mistakes and I think that's one of the things, the old system where the nurse manager got the report of an occurrence or adverse event report and we really didn’t know what happened. This made all the mistakes transparent. We kept names out of it and yet we still got a lot of work done and posted new policies and procedures, as well as new clinical practice measures. So an independent checklist, truly, rather than just look at my [inaudible] or my synthroid, looks good to me. What really is a dosage you’re giving? We did this for years and it’s actually kind of scary.

Define best practices— one of the things we added in the national program, because of my work with the advent of healthcare was the line maintenance. We know that and I keep hearing Peter say, if the infection is within five days, chances are it’s replacement and if it’s after five days then it’s maintenance. I don’t know if I believe that, so much. However, line maintenance does play a significant role and when you think you’ve gotten as far as you can, if you aren’t doing the audits we talked about then you’re doing yourself a disservice because you can identify a lot of things.

One of my hospitals wanted to show a video on how to appropriately change a central line dressing. By the time they were done they watched eight different nurses do a central line dressing in the lab on a manikin. The reason they had eight different nurses was because they saw these nurses do eight different dressing changes. Some had extra components, even though they had a dressing change fit. Have we standardized anything? No. Yet, this has been going on for a long time, so that made them add to their annual skill say.

Not only do they have to make sure that they can use [inaudible] they had to make sure that they did the dressing change appropriately, as well. I think things like that are very important.
We hear this and dance around it all the time and we do speak different languages, feel different things and this comes right out of our data. What this means over here is, the physician is saying he likes collaborating with the nurses. We see that since 1990 there have been tons of articles about collaboration, inner collaboration and improved patient outcome. Yet, that 88% saying I love the nurses I work with. Do you know what that really says? When I tell the nurse to do something he or she does it. Why the nurses are unhappy and why this really has to have front line staff ownership is because we’re unhappy.

For those of us that didn’t tell the doctor inaudible, Nicole, the doctor would play tricks on them and not put the inaudible and we didn’t say anything to them. The reason is because we’re afraid of being yelled at. We’ve been yelled at before, it’s not appropriate. The nurses at Hopkins say, I don’t feel like I’m babysitting. When you change it from you’re not babysitting the doctor or PA or the nurse practitioner, you’re both just trying to provide really good quality care. So now they’re saying they’re somewhat happy, but the reason we’re not happy is because you’re not asking my opinion.

This data is only a couple years old and we’ve gone from not including the nurse to including the nurse and the nurse actually has a say over what things you need to apply today. Now we have open ICU, with the patient’s family sleeping there. The door is open and you’re hearing everything they’re saying and the nurse is saying I need to get Mrs. So and So this, I need to get Mrs. So and So that. So not only is the nurse listening to, I’ve seen the overall data and we’ve gone up to about a 65% upgrade. Like I said culture change is slow. This is the difference between the doctors and the nurses and the ICU. It’s even worse than the OR, for those of you who work in the OR.

So the scorecard of how we got there, how often do we harm? If you look at this and we’re talking seven years ago, this is what the data looked like for the Michigan program. Some people say it doesn’t seem bad to me at all. In fact, I have inaudible that I work with and he’s happy with anything under five. I’m like that is horrible do you know what the mortality rate is with that? Then if you look at some of the correlations across or cross correlations of, have we created a soft culture?

In 2004, Michigan keystone say 84% of safety and 82% of teamwork they needed that kind of improvement. Eight percent of the 113 ICUs needed safety climate improvement they needed teamwork and climate improvement. When I say slow I mean it. It’s pretty significant, almost 50% of them still needs work on culture. This improvement all occurred because we have doctors and nurses, front line staff, senior executives, people from all levels coming together to eradicate what shouldn’t happen and naturally that’s why we see the change.

It’s a common goal and it is the patients, who we’re supposed to put forward. Teamwork climate across Michigan, just to emphasize and we’re going back a little bit just to see because you all have really come a long way. I want you to see that. This is what we attributed. The higher your teamwork climate was the less likely that you had a BSI and for the greater time period. Some of you said, will we ever get to zero and this talk is really, can we be a zero?

We’ve had units at Hopkins without a bio-patch, even though the bio-patch representative FEM said hi, nice to meet you, I heard you’re using the bio-patch, how do you like it? We don’t use the bio-patch inaudible, I don’t know who tells everybody we do. We don’t use it. We haven’t had a BSI in four years in one of our ICU’s. So you can go a long time. The other thing, and we’ve all talked about this, so I would say to Nicole, the strongest predictor is caregivers feel comfortable speaking up if they perceive a problem with patient care. If they’re letting that doctor, even though he’s the nicest guy to skip that, and he’s settling it the right way. You should never address issues with patients in front of everybody, you should pull them aside. I’m pleased to hear that that’s what he’s doing.

If they aren’t doing it, what we had to do with Hopkins was to implement assertiveness training. We had to do a lot of it and we had to make sure the nurse managers supported them and that senior managers supported them and that senior executives then supported the nurse managers when the physicians still had a fit.

Climate and nurse turnover– again I’m going to talk about this. If you look at this see this is the Cusp Program we’re supposed to be happy working on this. We’re improving patient care. I’m working with doctors I like.
Look at this, sort of sad reporting a positive teamwork climate. Some of them less than 5% a whole ICU felt they worked in a good climate. It didn’t do so great, because at that time, any time we were at 60% or below we said that ICU needs an intervention. All the ICUs needed an intervention. Look a little bit farther, so here are the doctors again, are very happy doctors and for those doctors in the room, I’m glad that somebody is happy, because imagine how miserable it would be to work in these units, how miserable it must be to come to work everyday.

You know what though it’s not just the doctors and nurses because it’s that when they’re inaudible we do sort them. I pretty much speak like Peter now, but it wasn’t always that way. They’re not very happy either, at 25% that’s pretty miserable. You have that one down here at 18%. It’s contagious, so if you’re unhappy in your work environment then you’re unhappy. This is what we found at the end of that study and we can’t really take the risk of losing nurses, especially when we have such a vacancy rate these days. This is what we saw.

So those people that had better climate had a lower nursing turnover and that’s what I found in my effective study as well, the higher the nursing turnover the higher the BSI rate, something to think about when you’re looking at it. That’s a perspective because somehow we make number one of that poll every year, John Hopkins number one. I always say to my inaudible, if we’re number one I wonder what number two is like. Because, there is plenty that goes wrong within our environment, so safety climate needs improvement, teamwork climate needs improvement but we’re feeling pretty good because we’re not quite so bad as all the hospitals in Michigan.

It’s not a really fair comparison though, because this is just one hospital in 98 clinical areas and by the end of three years we moved much lower than Michigan. We did not have the same cathartic experiences that Michigan doctors had that said, you know what, I enjoy coming to work everyday. However, we did see change over time and I think that’s what’s important. Culture change for our SICU where most of the work was done, we didn’t get to and above needs improvements until the third year, that’s how slow culture change actually occurred.

Of course the checklist, which I tell you, so you believe me now it’s just one more thing to do the right thing. It definitely is not a mechanism to prevent error, like Dr. Gawande said. I wish it was, but if you don’t empower those nurses or your front line staff in the OR, the anesthesia techs then we’re really not going to get the results that we want. And it came about, where do we borrow that from? Does anybody know? Aviation that’s right, actually the Department of Defense used this report on general aviation. So it was our Air Force to decrease reliance on memory, if any of you have ever heard Brian Sexton talk, on a good day we can remember seven, plus or minus, four things.

So the best of us on a good day remember 11 and on our work day we’re going to remember like three or four things. So this multitasking and some of the things we’re not good at, there’s a reason we’re not good at it. We weren’t programmed to be multitaskers.

Why the checklists? Ensure care is delivered. It’s not delivered if Nicole’s staff doesn’t step up and say hey, I need to do this. That’s where we were finding a lot of inaudible and I have some examples to show you later. Link evidence based practice measures to develop best-practices. I think that’s what’s important, so you can take everything you know that needs to happen, put it in your checklist and then hope somebody is going to implement it wholly.

These are where Peter got the idea of making it more well-rounded for just one area so the BSI reduction first happened and it’s an article written by a colleague of ours, Shawn. Daily goals and then reconciliation, so on very few medical papers did they deem that checklists are a viable way to reduce patient safety events. This is a long process, I’m not kidding you. Translating evidence into practice, the adaptive and technical component issues…the technical part was easy. It was easy to search a list and come up with the evidence based practice bundle. The adaptive piece that we talk about has to do with the culture that we face in our own unit and what it’s like, that took a long time.

Unsure of what success would really look like, because we had not had big wins. I mean, yeah it’s Peter Parvos and John Hopkins, but not quite as quickly as you see when I show you the data and how much work it is to do this.
This is the trip. How we get to zero is, we had to do a lot of things. We had to put together a bundle and then based on that bundle we had to develop the checklist, which comes in here. Then we had to observe our staff performing intervention, so this had to say, why isn’t this working for you? Then take what they told us to heart and we had to make changes by the staff. So any time we develop a teamwork tool, checklist, anything like that and we say it comes from our perspective, it doesn’t mean it’s coming from your perspective.

If we’re going to get to zero, if we’re going to move Cusp along, every tool we make you have to take it and make it your own. If this is John Hopkins’ it’s not going to make it. If you say you know what, we don’t need a morning briefing tool in our ICU we need more of a morning huddle and these are our three questions. They’re just really to give you ideas about what to do.

Measure your performance, again a lot of people worked with this that said you know, I can’t believe they’re doing it for that, we did the IHI 100,000 lines. I said you shouldn’t kick yourself because the difference between that kind of collaborative and this kind is they didn’t ask for your numerator and denominator and without data you don’t know how you’re doing. So unless you have an infection process that reports data back to you, you won’t know how well you did or didn’t do and then again the four ‘Es’ to put it all together to have something that was going to allow you to do all of those compliance and actually implement and evaluate your performance.

Standardize – this started out and I know somebody with the NICU borrowed a cart, we got a Sears Roebuck. Somebody gave us a Sears Roebuck inaudible and that’s what we used. Eventually, I don’t know whether we painted it or bought something else, but after a while they would actually spend money on something outside of Sears Roebuck. It was not only standardized, but standardized in all four ways and this began how we started to standardize everything. So, if we could do it, the two pieces of equipment that had to go together like a pacer and pacing wire. I can’t tell you how many times the resident would find two things, a pacer and pacing wire that didn’t fit together we started packaging.

So we did it the easy way and we packaged everything that was supposed to be together, together so human error didn’t happen. Standardization was key in getting where we are today. You talk about embarrassing, going up and down. If you look at the slide, in the SICU, can you imagine your rate is 22? Again, how do you approach this? We had a bad policy. Guess what, policy and procedures and an educational process are the weakest ways to bring about change. It works for a little while, line cart because just like you the residents had to go eight places and had to go to a locked cart to get that central line.

We’ve got it made, no. Daily goals, we’re not taking them out and we’ve tried multiple methods to get them out. We even have a series of questions now, because somebody would say do we have to get an order? No. If they meet certain criteria as some of the hospitals I’ve worked with, no longer being by and transfused, no longer multiple antibiotic, if they meet these five criteria the nurse is allowed to take out the central line and that’s how we did this.

Add the checklist, yay, everything has happened? No, kind of settled at 2 ½, so we’re just about the average at this point, but who wants to be average, as Peter would say? Empower the nurses and we did this hospital-wide and that’s when we got four years with no infections. So, it’s that empowerment piece. The checklists really, you know what it says did you wash your hands? Did you use the full measure of precautions and if you didn’t the nurse is supposed to redirect you to do the right thing. However, if they’ve ever been yelled at then they’re less likely to speak. If they have a good relationship and let’s say you’re really high up the totem pole, you might be say dean from the School of Medicine, they’re less likely to talk to you.

If you met with them at a Cusp meeting or senior executive round and you’ve developed that first name basis, because we always say names first. It shouldn’t be hi Dr. so and so, like I’m really not Dr. Thompson I’m just David. Peter calls me Dr. David to tease me. First names, so Peter, John, what are you doing calling me on my anniversary and I could hear his wife in the background laughing and my wife saying, it’s going in the ocean. This really happened but I can do that with him. Maybe 10 years ago I couldn’t, but certainly can now.
Outcome—so you saw the tragic John Hopkins numbers. I couldn't believe it. This is what our hospital's epidemiology department. Thank God for the infection preventionist, because they actually had the correct numbers. Our mene was about 11.3 per 1000 catheters and we got it down to 2 ½, which was the mission average within that year. Those were the prevented deaths CLABSis and ICU days estimated with that, that was a cost savings at the time, which was thirty some thousand dollars. We're still only average, so what did we do? That's when we went into the initiative program and honed our skills a little bit and got even better.

The piece I want to mention more, getting to zero is staff empowerment. They shouldn't be just empowered to stop the line or stop takeoff, but they should be empowered to stop anything that puts a patient at risk. That was a hard lesson for us to learn and what we ended up implementing was a patient safety advocate or officer, 24 hours a day, seven days a week that could be available night or day and they got phone calls. Before that it was Peter or Dean Miller passing out their cards and saying call me if there are any issues and they hardly ever got called.

However, a nurse in the role as a patient safety officer who had all those senior executives at her command was very helpful and it made a huge difference. We would track people that had been yelled at, whether you are a physician or nurse you were less likely to ever approach that other person again because it's not worth being yelled at again. I've even seen people come to fists up, dragging people out of the ICU to punch each other out. That culture, I thought it was laughable when I first heard it and it's true.

So staff empowerment— with that staff empowerment was the approach that everybody needs to do it and I get it from doctors all the time. I need to take assertiveness training because I'm the infection preventionist, but I work here for the hospital and there are two of us, and if I tell Dr. Sellers the Cardiac Surgeon I don't like him ordering triples without my consult, what that means is he's not going to refer anymore patients to me. And what that does to my bottom line is, I'm not going to have enough patients to pay my way in this hospital and they're going to ask me to leave. I never knew that could potentially happen but it does happen, so I have physicians training with the nurses and now we teach our med students and nursing students at the same time.

They have a three day communication training session that we offer to the School of Medicine and School of Nursing Students and to all our research fellows as well, because you have to be empowered and assertive to be good advocate for your patient.

This is my work and yet, can we get to zero. I think Tonya mentioned this when we came in. This was a little different than what Peter did. Mine was a nursing driven protocol but was the same five pieces of evidence. The difference was I had the nurses lead the whole evidence based practice bundle Cusp initiative. It was interdisciplinary in that they had to work with physicians that they had to work that out for themselves and Adventis Health was non-teaching and had no affiliation of academics so these nurses were used to physicians and just doing what they were told. We got off to a very rocky start.

Our goal though, was to see the impact of nurses, what the fill mix was like and all our ICUs had better outcomes than RNs with nurse assistants. Were they able to say to the CRV aside bundle and they also wanted to see the impact of these other activities, nursing hours per patient day and then that was on rate for annual nurse turnover. What we got with our nurses was pretty astounding. We had within the first couple of months in our intervention group we had an 80% reduction which made me really happy because in all of Michigan they only reduced their rate by 63%.

So I got to say I did better than Peter... that's a lot better than Peter... and he was the first to mention it, which was great. Do you know what else is great? This was done by nurses, completely. So it had a nurse director, me, a health services researcher and organizational psychologist. We didn't even have a physician on our board and we were able to get them to do this. Because we had such a striking change we turned the control book into intervention too and except for this blip where they thought the study was over and they had to stop doing what they were supposed to do, we would have had two groups at 81%.

What is nice is I stay in contact with Inventive Healthcare and just like the Michigan group they still maintain.
So it’s still alive and well because they change it and this is them being a religious affiliated healthcare system. They also felt that the mortality was untenable, even if it did mean 12 patients per year, and they continue to do this. Inaudible in nine months and it stayed there throughout the entire study.

What we found though, because there’s a lot of work in all of this. The doctors would hide the full barrier drapes in the supply cart before we had a training and they would take as many sterile towels as they needed to cover as much of the patient up as they went, rather than do the right thing. In fact, one nurse manager said this is my problem. I said what is it? I saw these cases of sterile towels and I said wow, you have a great supply and she said no, the stupid doctors order behind my back when I’m not there and this is what I found.

So to have that conversation and with a small IP they didn’t have a director of IP so I had to go to the chief medical officer, who said this will not happen again. That’s all he needed to say and they were like, one doctor said I don’t even work here. He said I think I’ll just stop admitting here. The other two work at this hospital too, so he had to suck it up and do the right thing.

Hats not worn by the physicians with no hair, I don’t know why it’s consistently a process of states that I’m working in, if you don’t have hair you don’t need hats, but you do. Hand washing not completed. In the OR and I’m sure you can relate, they’ll induce the patient before their cardiac surgery, they’ll go incubate somebody and then they’ll put the central line or whatever they decide to do. They don’t wash their hands, not to begin with and not between procedures even though they’ve just got that down and the scrub nurse school will see a glob of stuff all over and they go its fine it’s just sterile surgeon lube. I go how do you know? You’re just like this is really gross, they don’t even have regular gloves on so we really had to start back with square one.

I thought everybody was compliant. I thought everybody was well behaved and then, just like you all had to do audits I started auditing the caregivers around me and yes we got to zero, but it was a long and painful process.

Daily goals— so some people said this didn’t necessarily work for them. This was very helpful for us to get there because not only did it allow you to have a systematic view of the patients system, we added a lot of information that our infection preventionist wanted and that our pharmacist wanted. We had where the culture swab was taken. If they were here this long were they on prophylaxis for a fungal infection? All kinds of things, they were checkboxes on the list. There was no way we could make a mistake if we actually followed this and we did it well.

The system we set up was we’d have the attending direct rounds. We had the residents coming off would get the report on the patients. The attending coming on would transcribe all the orders and we’d have the nurse to include them in there, even the nurse from other residents would then have to fill out the daily goal sheet. At the end of it the nurse would read what the goals were for today. Not only did it work— and I know many of you have seen this before— we went from a 5% understanding of what we were actually supposed to do for our patients at Johns Hopkins, which was not so great, to 95% of the time we knew what we needed to do to get our patient out of the ICU.

That included taking out the central line, which is why the criteria of we’re no longer fluid resuscitating, we’re actually inaudible them and they’re no longer on triple antibiotics and they’re not getting transfusions. Daily goals reduced our length of stay. Remember how I said we have to make our CFO’s happy and the Chief Operating Officers, we showed them this data and most internal databases within your hospital can provide this to you, 654 new admissions does in 1-12 bed ICU $7 million in additional revenue has made them happy.

Does it have anything to do with me getting a zero? Absolutely! I was going to say absolutely not, but it absolutely does because we have their support. We got the supplies we needed. The daily goals were made mandatory, all physicians had to complete it, lines came out quicker, adverse events went down and actually recording went up because we had a change in culture and people were more transparent about error.
In summary… to advance the science of quality improvement and TRIP, it really is work from front line providers up and let the senior executives know what you need. You get to do that in your relationship that you have with them through the Cusp team. Identify your local barriers to implementation, again value those inaudible, so that cardiac surgeon who doesn’t want to work with you, Sarah. I’ve met a couple of them before too.

Really, we started an inventive thing, started showing two positions that continued to use the femoral line that were dropped, elevating their rates at two inventive hospitals and it was 45 IPs from 35 different hospitals. It was the infections disease nurse, who actually showed the attending physician who was still using femoral line what his infection rates were on a piece of paper like this, compared to everybody else. I wouldn’t recommend that, but he got the point and he followed the ER doctor learning how to put in IHAs and subclavian.

Measure your performance without numbers, we really don’t know how well we’re doing and I think the last thing is, is just to think about some of the things that makes your hospital special. What would really get their attention, in order to do this? For us it was that harm is untenable and mortality was unacceptable at any rate. I think that was important, and not to mention that nobody ever set a goal to be average so if your goal is just to be with the national average, which goes totally against what National BSI Program was about. It was to make sure you address BSI and all kinds of patient safety in regards to the Cusp Program.

If you have questions, please contact Stratis Health, at info@stratishealth.org.