

Unified Quality Improvement Symposium January 31, 2018

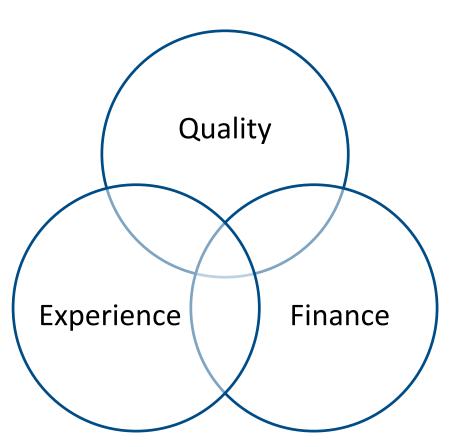


A Collaborative Approach to Reducing Central Line-Associated Blood Stream Infections (CLABSI)

Diana Layne RN, MSN, CPHQ

Significance





- Estimated 30,100 CLABSIs occur in ICUs and acute wards annually¹
- Between 84,000 and 204,000
 CLABSIs per year resulting in 25,000 preventable deaths accounting for up to \$21 billion in costs annually²

¹CDC National and State Healthcare Progress Report. 2014. Available at: https://www.cdc.gov/HAI/pdfs/progress-report.pdf Accessed January 15, 2018

² Umscheid CA, Mitchell MD, Doshi JA, et al. Estimating the proportion of healthcare-associated infections that are reasonably preventable and the related mortality and costs. Infect Control Hosp Epidemiol 2011;32(2):101–14.

Collaborative Team Members





Tara.Stroud@vidanthealth.com

Tara Stroud

252-816-3742

VDowning@vidanthealth.com

Vickie Downing

252-847-9157

Project Aim



Achieve VMC FY' 2017 reduction target of 7% over prior year performance by September 2017

Roadmap to Success





- Utilize data to drive improvement
- Identify existing gaps
- Develop a strategy to mitigate drift

Recognizing Improvement



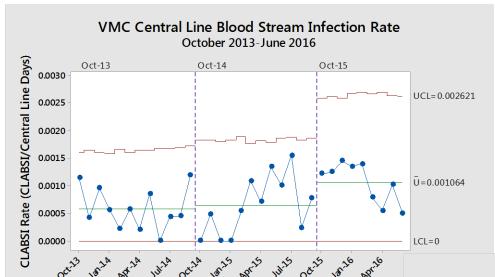
Improvement occurs when:

- Raw numbers of CLABSI are decreased
- Best practice performance improves
- Improved outcomes on independent third party assessment



The Starting Line



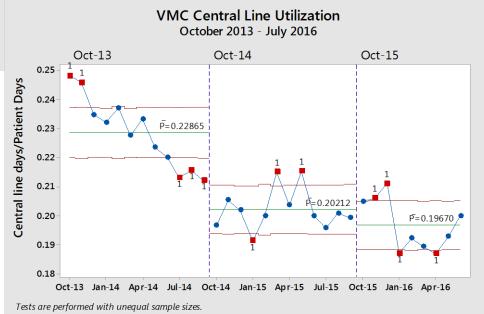


Date

Rate of infection continued to rise

While utilization continued to decrease

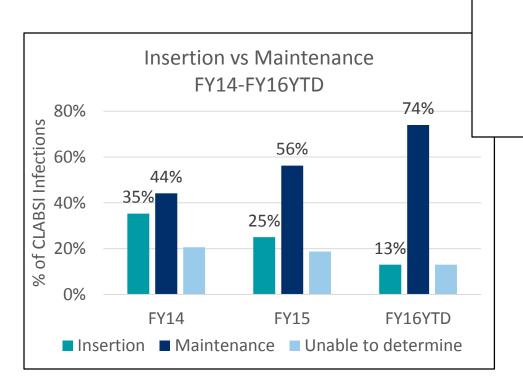
Tests are performed with unequal sample sizes.



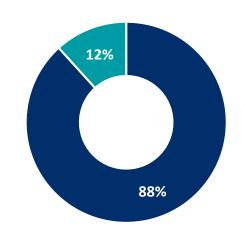
More to the Story



Best practice bundle compliance FYTD was not highly reliable only a single month was above 95%



CVL Best Practice Bundle Compliance FY 2016 (n-819)



Maintenance related infections are increasing while insertion related are decreasing

Initial Assessments 98 Assessments



All Line Assessment 98 total observations

Staged Assessment 39 total observations

 10 elements to prevent infection • 4 critical skills

- Dressing observation (6)
- CHG presence (3)
- Focused on catheter securement(1)

- Dressing change
- Blood draw
- Flush/medication administration
- Hub maintenance

The Progression



Garner Support from Key Stakeholders (Jul '16) Conduct initial quarterly assessment of maintenance practices

(May '17)

Modify Best Practice
Bundle to include
placement of antimicrobial
patch
(Aug '17)

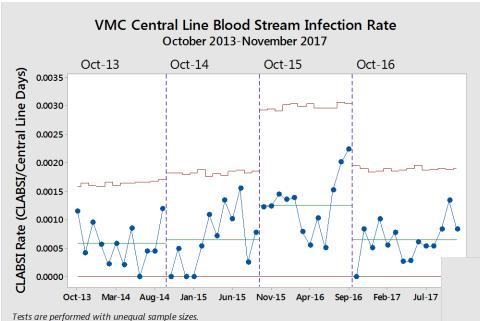
Identify Operations Leaders as Project Champions (Sept '16)

Reevaluate training efforts (Feb '17)

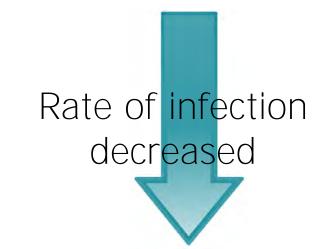
Conduct Failure Modes Effects Analysis (FMEA) (Sept '16) Train all RN staff on proper maintenance
(Nov '16- Jan '17)

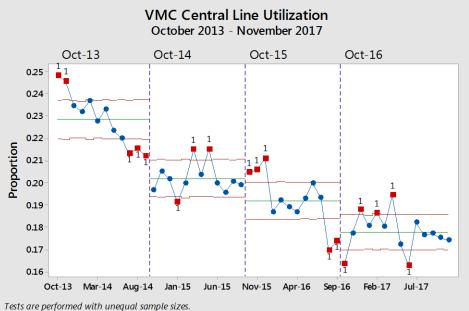
The Finish Line





While utilization continued to decrease





Follow up Assessment 118 Assessments



All Line Assessment 118 total observations

Staged Assessment 39 total observations

 10 elements to prevent infection • 4 critical skills

- Dressing observation (6)
- CHG presence (3)
- Focused on catheter securement (1)

- Dressing change
- Blood draw
- Flush/medication administration
- Hub maintenance

Obstacles to Change



Analysis Paralysis

What if

Group Think

That is just how we do it

Lessons Learned Through QI Efforts



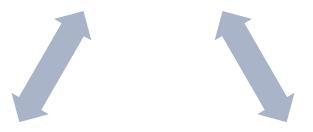


Just remember the mistakes you made yesterday are helping you make the right decisions today that you will be proud of tomorrow- *Mark Amend*

Preventing Drift



Continued Quarterly
Assessment
(measure performance)



Communication
Cascade
(Celebrate/Redirect)

Refine/align quarterly data collection
(Evaluate and modify)





Diana Layne, RN, MSN, CPHQ 252-847-2512 dlayne@vidanthealth.com