TENNESSEE CENTER FOR Patient Safety

THA
TENNESSEE HOSPITAL ASSOCIATION

Storyboard Showcase

Making Safe, Quality Care the Top Priority

Tennessee Hospital Collaborative on Reducing Healthcare-Acquired Infections

Statewide Conference
October 6, 2011

Baptist Memorial Hospital for Women
Memphis, TN

Carol Thetford, Chief Nursing Officer
Carol.Thetford@bmhcc.org

Beverly Reed, NICU Research Nurse
Beverly.Reed@bmhcc.org

Title: *Breast Milk Safety*

Click here to view the complete abstract and photos of this storyboard.

Purpose: With more moms providing expressed breast milk for their NICU babies, we needed to eliminate/minimize the opportunity for breast milk errors.

Major Outcomes: Utilizing our computerized medication documentation system to double check breast milk before delivery has eliminated the human double check at the bedside, saving nursing time and reducing the opportunity for error.

Conclusions, Lessons Learned, Implications: By utilizing our computerized medication documentation system for double checking breast milk, we not only saved nursing time and reduced errors, we also saved money by not adding yet another system. But no system or process is without faults and nurses do find work arounds, therefore, we continue to monitor this process.

Baptist Memorial Hospital Memphis
Memphis, TN

Lisa Moore, RN, CPHRM, Director Infection Prevention/Risk Management/Patient Relations
Lisa.Moore@bmhcc.org

Title: *Unit Based Patient Safety Officers (UBPSO) – Patient Safety Collaborative*

Click here to view the complete abstract and photos of this storyboard.

Purpose: Promoting a culture of safety and application of evidence-based practices; Trending of adverse event reporting for performance improvement; Providing patient and environmental safety education on an ongoing basis; Spreading of safety initiatives and lessons learned from events; Fostering an environment of Excellence

Major Outcomes: The initiatives implemented resulted in sustained improvement over time including: 46% reduction in ICU mortality; 34% reduction in ICU Length of Stay; 80% reduction in CLABI rate; 46% reduction in VAP rate; 37% decrease in ventilator LOS; 47% decrease in CAUTI rate

Conclusions, Lessons Learned, Implications: Continue to reward near misses by promoting “Patient Safety Champions” program to recognize publicly the commitment of the organization to the culture of safety; Collaborate with other entity safety teams (i.e. falls, LILY, medication safety, etc.) to accelerate the spread of “lessons learned” throughout the organization; Empower frontline providers to investigate safety defects, drilldown to the contributing factors, and implement change to prevent recurrence; Respect the wisdom and observations of the frontline staff in making decisions regarding equipment, supplies, and tools utilized at the level of the patient; Empower beside caregivers to “stop the line” if patient safety practices are not observed; Embrace the concept of “patient/family centered care”.

Johnson City Medical Center *Johnson City, TN* Libby Johnson, Infection Preventionist Johnsonld@msha.com	**Purpose:** Collaborative team project to reduce VAP in the adult population. **Major Outcomes:** The project has dramatically reduced VAP in the adult intensive care units (ICUs) from 38 cases in 2005 to 3 cases in FY11, and significantly decreased ventilator utilization ratio's and ICU days. Johnson City Medical Center was recipient of the U.S. Department of Health and Human Services and Critical Care Societies collaborative *Outstanding Leadership Award* in eliminating VAP. **Conclusions, Lessons Learned, Implications:** Leadership, sustained culture of safety, establishing a team of champions to achieve better outcomes, standardized tools, and scripted rounds are all key in the success of CLABSI reduction for Johnson City Medical Center.
Title: *Preventing Ventilator-Associated Pneumonia (VAP)* Click here to view the complete abstract and photos of this storyboard.	

Memorial Health Care System *Chattanooga, TN* Rhonda Poulson RN, BSN, MBA, CCRN, Director of Critical Care Rhonda_Poulson@memorial.org	**Purpose:** To provide patient safety through alternate means of distraction and prevention in order to decrease the use of restraints in the target population. **Major Outcomes:** Continued change in the practice of restraints and supporting evidence; Ongoing reassessment after initial application of restraints; Use of alternate methods: activity blanket, mittens, and increased monitoring, can reduce the need and use of physical restraints; Improved patient safety outcomes by managing nursing assignments based on acuity and level of supervision; Adequate use of sedation and analgesia can help to reduce the need for restraining therapies in certain patient populations as it pertains to their disease process or medical issue. **Conclusions, Lessons Learned, Implications:** Staff awareness and desire to put the patient first is the major obstacle in reducing restraint usage. Bad habits are hard to break. Nurse managers have to be diligent to question in daily rounding to need for restraints. Changing attitudes and culture is the greatest challenge. We have cut restraint usage by 90% at on both campuses while maintaining low fall rates and no rise in extubations. We have 55 critical care beds and 8 PCU beds. Our ventilator days have continued to rise while sustaining restraint reduction.
Title: *Reducing Restraints in Critical Care* Click here to view the complete abstract and photos of this storyboard.	

Saint Thomas Hospital
Nashville, TN

Hence, D. A., RN
dhence@stthomas.org

Lim, N. Z., MPH, RN
Powers, C., RN
Snow, T., RN
Ferebee, D., RN
Marsden, M., MD
Neal, M., RN
Esper-Kanze, C., RN
Stankewicz, M., MD
Tacker, G., RN
Walpole, H., MD

Title: *STEMI Committee: Improving the care of the STEMI Patient*

Click here to view the complete abstract and photos of this storyboard.

Purpose: To reduce the time to coronary vessel reperfusion through improved coordination and timing of care for the STEMI patient.

Major Outcomes: With the change in D2D2B process of patients going directly to the cardiac catheterization laboratory upon arrival, there was a 33 minute (48.5%) reduction in time to reperfusion. Reduction in mean reperfusion times for D2B and B2B were also noted (15.6%, 23.9%).

Conclusions, Lessons Learned, Implications: A multidisciplinary team approach was successful in improving the care of STEMI patients. Improvement efforts and care team engagement where enhanced when all stakeholders were involved. The committee is committed to continuous improvement efforts: including review of aggregate and individual case data and process step goals.

Vanderbilt University Hospital
(NICU & PCCU)
Nashville, TN

Tanya Boswell, MSN, RN, Infection Consultant
Tanya.Boswell@vanderbilt.edu

Jackie Smith, MSN, RN, Infection Consultant
Jackie.Smith@vanderbilt.edu

Title: *It's Contagious! CLABSI Prevention is Spreading.*

Click here to view the complete abstract and photos of this storyboard.

Purpose: Standardizing central venous catheter care throughout Monroe Carell Jr. Children's Hospital at Vanderbilt.

Major Outcomes: Central line-associated bloodstream infection (CLABSI) rates throughout the institution decreased as a result of standardizing the care of central venous lines.

Conclusions, Lessons Learned, Implications: Collaboration from all areas of the institution is necessary to develop a standardization of central venous line care and foster a zero tolerance culture.

Vanderbilt University Medical Center (MICU)
Nashville, TN

Christine Kennedy RN, MSN, NEA-BC
Administrative Director of Inpatient Medicine
Christine.a.kennedy@Vanderbilt.edu

Title: *Sustained reduction of CLABSI in a Medical Intensive Care Unit*

Click here to view the complete abstract and photos of this storyboard.

Purpose: To decrease central line associated bloodstream infections in an adult medical intensive care unit (MICU).

Major Outcomes: FY 2011 the average CLABSI rate was 2.32 per 1000 device days. Year-to-date FY 2012 the average CLABSI rate is 0 per 1000 device days. As of 9.26.11 we are sitting at 145 days since our last CLABSI. The line insertion carts have been rolled out initially to all of the intensive care units at this hospital and are now in place for the whole hospital.

Conclusions, Lessons Learned, Implications: Because we implemented so many things at the same time it is difficult to know the effects of individual action steps. One of the key learnings was that by making this personal – giving these data names of patients who had central line associated bloodstream infections and their outcomes helped the whole MICU team to own this problem and commit to turning it around.

Vanderbilt University Medical Center (SICU)
Nashville, TN

David R. Meyer, RN, MBA, Manager SICU
david.r.meyer@vanderbilt.edu

Ashley Staniewski-Davis, RN, MSN, Assistant Manager SICU
Ashley.n.davis@vanderbilt.edu

Lorrie Ingram, BSN, RN, CIC Infection Control & Quality
lorrie.g.ingram@vanderbilt.edu

Christy Thomas, RN, Staff Nurse IV, CCRN, SICU Procedure Nurse
Christy.l.thomas@vanderbilt.edu

Barbara Gray, BSN, RN, Quality Consultant Surgery/Trauma PCC
barbara.gray@vanderbilt.edu

John Rice, BSN, RN, Staff Nurse IV, SICU
john.rice@vanderbilt.edu

Title: *An Amazing Race…Running to Zero CLABSIs*

Click here to view the complete abstract and photos of this storyboard.

Purpose: One surgical intensive care unit's journey to decrease central line-associated bloodstream infection rates (targeting zero), including standardizing central line care and maintenance.

Major Outcomes: CLABSI rates in the surgical intensive care unit began to reflect a downward trend. Currently the unit is at 330 days, and working on a year without a CLABSI.

Conclusions, Lessons Learned, Implications: 1.) Importance of engagement of all stakeholders is necessary to collaborate and manage processes. 2.) Comprehensive education for staff/patients/families is important for acceptance of management and compliance 3.) Rounding, tracking, and involvement of front line staff to ensure consistency and reliability with processes are necessary.

Williamson Medical Center
Franklin, TN

Vicki Sweeney, RN
vsweeney@wmed.org

Ashley Perkins, RN
Titus L. Daniels, MD, MPH

Title: *Use of a Centralized Process to Reduce Central Venous Catheter Utilization*

Click here to view the complete abstract and photos of this storyboard.

Purpose: Appropriate placement of central line catheters.

Major Outcomes: The number of PICCs per month decreased by more than 50% (85 to 40). PICC appropriateness increased by 50%, t greater than 93%. As of September 26, 2011 we are 512 days without a CLABSI.

Conclusions, Lessons Learned, Implications: Input from staff and physicians is necessary to create a culture change and gather support; Education must be presented in several formats to allow for input and support; Face-to-Face unit presentations gathered the most support for the plan; PICC appropriateness has increased from 47% to 93% in a 12 month study; There has been a 51% decrease in PICC utilization; WMC has not had a CLABSI for 17 months.