4th Annual Wyoming Infection Prevention Conference

Risk Assessment, IP Plan and QAPI

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Chief Quality Officer
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Whidbey General Hospital and Clinics
Infection Preventionist Competency Model

• Specific core competencies are defined by the Certification Board of Infection Control and Epidemiology (CBIC)

• Extending from these core competencies are 4 domains developmental domains
  – Build on the core competencies
  – Achievement helps move infection preventionist (IP) from novice to expert
4 Domains of APIC’s Competency Model

- Leadership and Program Management
- Performance Improvement and Implementation of Science Domain
- Infection Prevention and Control Domain
- Technical Domain
Goals of the Infection Prevention Program

• Decrease risk of infection to patients and personnel
• Monitor for occurrence of infection and implement control measures
• Find and correct issues relating to infection prevention practices
• Minimize unprotected exposure to pathogens
• Minimize risk associated with procedures, medical devices and equipment
• Sustain compliance with regulatory bodies related to infection prevention
Primary Activities

• Surveillance and control measures to prevent infections
• Outbreak investigation
• Policy and procedure review and revisions
• Education; staff and patients
• Performance improvement
• Content expertise and resource, the infection preventionist is a resource for all staff and departments
The Infection Prevention Program Plan

• Risk Assessment
• Assessment of services provided
• Assessment of populations served
• Prioritized strategies for risk reduction
• Surveillance plan including data analysis
• Plan is reviewed annually or as often as needed
Infection Control Risk Assessment Purpose

• Evaluation of potential risk for infections, contamination and exposures
  – Based on known risk, historical data and reports in literature
• Evaluation of harm
  – Life threatening, loss of function, loss of community trust, loss of organization good will, financial threat, legal and/or regulatory issues
• Evaluation of organization’s preparedness to eliminate or mitigate the harm or risk of harm
CMS Infection Prevention Worksheet

• 1. B.4 The hospital utilizes a risk assessment process to prioritize selection of quality indicators for infection prevention and control.
Review of Handouts

1. ICRA instructions (word doc)
2. WGH Geographic & Population Risk Assessment (word doc)
3. Infection Control. Prevention Risk Assessment (excel doc)
4. Infection Control & Prevention Progress Report (word doc)
ICRA Instructions Document

- Evaluate potential risk
  - Infection/contamination/exposure
  - In 3 categories
    - Probability
    - Impact
    - Current Systems
Probability Includes

- **Probability**
  - Known risks, historical data & reports in literature

- **Impact**
  - Threat to life and or health
  - Disruption of services
  - Loss of function
  - Loss of community trust
  - Financial impact
  - Legal issues
  - Regulatory/accrediting/organizational issues

- **Current Systems**
  - Status of current plans and implementation
  - Training status
  - Availability of backup systems
  - Community/Public Health resources
Scoring the Risk

- Multiply the ratings for each risk in the area of probability, impact and current systems
- Total the values
- Sort in descending order
- Determine a cut off value below which no action is necessary
- Review with organization for acceptance of priorities
Starting the Geographic and Population Risk Assessment
Geographic & Population Risk Assessment

• Descriptive analysis
  – Geographic area served
  – Environmental factors
  – Populations served
  – Breakdown of major payers
  – System issues
  – Other risks
# Example

**Whidbey General Hospital Infection Control & Prevention Assessment**  
**Geographic and Population Risk Assessment**

<table>
<thead>
<tr>
<th>Factors</th>
<th>Characteristics That Increase Risk</th>
<th>Characteristics that Decrease Risk</th>
</tr>
</thead>
</table>
| **Geographic & Environmental:**  
Whidbey Island lies 50 miles South of Canada, 30 miles North of Seattle. Served by ferries. 3 Distinct regions on the island, North Whidbey is home to the Naval Air Station with 7,600 military personnel and family members. Central Whidbey includes the village of Coupeville, population 1800, and Port Townsend Ferry connecting the island to the Olympic Peninsula. South Whidbey includes the towns of Langley and Freeland, population 20,000 mostly in rural settings. | Provider availability 1.4 per 1000 residents (2.4 WA & US). Critical Access Hospital isolated. Frequent bad weather (high wind/fog) hampers patient transfer to higher level of care (no ferries, no helicopter during high winds). Helicopter is based in Seattle- 25 minutes for arrival. Ferry is parked on Whidbey Island side and will run at night for emergencies. Rural 2 lane roads. Cell phone reception is spotty. | Low crime rate. Violent crimes (murder, rape, robbery or assault) 1.2/1000. (2.9 WA, 4.0 US) |
## Population Characteristics:
Not ethnically diverse, 4/4% residents consider themselves to be Asian and 2.2% African American. 18.4% is over the age of 65. Median household income is $53,754

### Factors | Characteristics That Increase Risk | Characteristics that Decrease Risk
--- | --- | ---
**Population Characteristics:**  
Not ethnically diverse, 4/4% residents consider themselves to be Asian and 2.2% African American. 18.4% is over the age of 65. Median household income is $53,754  
Unemployment rate 9% (WA 9.2% & US 8.9%)  
Individuals at or below Federal Poverty Level 9.4% (WA 13.4% & US 15.3%)  
Children in poverty 14.4% (WA 18.2% & US 21.6%)  
5% residents report a concern about having enough food for themselves or their family. 10% reported they ate less and 2% said they went hungry to address this concern.  
Adults age 25+ who are NOT high school graduates 2.9% (WA 10.2% & US 14.4%)  
Years of healthy life at age 20 (additional years a 20 yo is expected to live in good health) 54 (52 in WA & 48 in US)  
Percent of adults under 65 with health insurance 87% (84% WA, 83% US, 2012)  
Adults having a usual source of health care 82% (78% WA, 80% US)
### Example

**Other Area-related Risks:**
Environmental health, diseases transmitted by food, water or air.

<table>
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<tr>
<th>Factors</th>
<th>Characteristics That Increase Risk</th>
<th>Characteristics that Decrease Risk</th>
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</thead>
<tbody>
<tr>
<td>Salmonellosis rate 12/100,000 (12 WA, 15.2 US) Campylobacteriosis rate 14/100,000 (20 WA, 12/7 US) Shiga toxin producing E coli 0 (3 WA, 1.2 US) Giardiasis 12/100,000 (8 WA, 7/4 US) We have 56 beaches, 9 beaches are closed due to a pollution risk from a marina or sewage treatment plant.</td>
<td>Public health monitors contaminated shell fish. They evaluate shell fish habitat, marine water quality, and monitor shellfish and beaches for biotoxins, vibrio and pollution. Public health informs the public when a beach is closed.</td>
<td></td>
</tr>
</tbody>
</table>
### Medical Care Characteristics:

<table>
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<tr>
<th>Factors</th>
<th>Characteristics That Increase Risk</th>
<th>Characteristics that Decrease Risk</th>
</tr>
</thead>
<tbody>
<tr>
<td>Immunization coverage for kindergartners</td>
<td>Adults over age 65 immunized for flu 72% (71% WA, 70% US)</td>
<td>Adults over age 65 immunized for pneumonia 70% (71% WA, 69% US)</td>
</tr>
<tr>
<td>Pregnant women who received prenatal care in</td>
<td>Adults over age 65 immunized for pneumonia 70% (71% WA, 69% US)</td>
<td>WA early adopter of Obama’s affordable care act insurance. WGH has 7 trained enrolers to assist</td>
</tr>
<tr>
<td>first trimester 80% (77% WA, 72% US)</td>
<td>WA early adopter of Obama’s affordable care act insurance. WGH has 7 trained enrolers to assist</td>
<td>residents in attaining insurance.</td>
</tr>
<tr>
<td>Adolescent pregnancy rate 14/100,000</td>
<td>WA early adopter of Obama’s affordable care act insurance. WGH has 7 trained enrolers to assist</td>
<td>WA early adopter of Obama’s affordable care act insurance. WGH has 7 trained enrolers to assist</td>
</tr>
<tr>
<td>(WA 27, US 40).</td>
<td>residents in attaining insurance.</td>
<td>residents in attaining insurance.</td>
</tr>
<tr>
<td>Adults overweight or obese 65% (62% WA, 69%</td>
<td>WA early adopter of Obama’s affordable care act insurance. WGH has 7 trained enrolers to assist</td>
<td>WA early adopter of Obama’s affordable care act insurance. WGH has 7 trained enrolers to assist</td>
</tr>
<tr>
<td>US)</td>
<td>residents in attaining insurance.</td>
<td>residents in attaining insurance.</td>
</tr>
<tr>
<td>Adults reporting 8 or more mental health</td>
<td>WA early adopter of Obama’s affordable care act insurance. WGH has 7 trained enrolers to assist</td>
<td>WA early adopter of Obama’s affordable care act insurance. WGH has 7 trained enrolers to assist</td>
</tr>
<tr>
<td>days per month 15% (13% WA)</td>
<td>residents in attaining insurance.</td>
<td>residents in attaining insurance.</td>
</tr>
<tr>
<td>Youth reporting seriously considering</td>
<td>WA early adopter of Obama’s affordable care act insurance. WGH has 7 trained enrolers to assist</td>
<td>WA early adopter of Obama’s affordable care act insurance. WGH has 7 trained enrolers to assist</td>
</tr>
<tr>
<td>suicide in the past year (10th graders)</td>
<td>residents in attaining insurance.</td>
<td>residents in attaining insurance.</td>
</tr>
<tr>
<td>16% (18% WA)</td>
<td>WA early adopter of Obama’s affordable care act insurance. WGH has 7 trained enrolers to assist</td>
<td>WA early adopter of Obama’s affordable care act insurance. WGH has 7 trained enrolers to assist</td>
</tr>
<tr>
<td>Cigarette use in 10th graders 13% (13% WA)</td>
<td>residents in attaining insurance.</td>
<td>residents in attaining insurance.</td>
</tr>
<tr>
<td>Smoking rates among adults 15% (15% WA, 18%</td>
<td>WA early adopter of Obama’s affordable care act insurance. WGH has 7 trained enrolers to assist</td>
<td>WA early adopter of Obama’s affordable care act insurance. WGH has 7 trained enrolers to assist</td>
</tr>
<tr>
<td>US)</td>
<td>residents in attaining insurance.</td>
<td>residents in attaining insurance.</td>
</tr>
<tr>
<td>Alcohol use among 10th graders 24% (28% WA)</td>
<td>WA early adopter of Obama’s affordable care act insurance. WGH has 7 trained enrolers to assist</td>
<td>WA early adopter of Obama’s affordable care act insurance. WGH has 7 trained enrolers to assist</td>
</tr>
<tr>
<td>Adult alcohol use with focus on binge-drinking</td>
<td>residents in attaining insurance.</td>
<td>residents in attaining insurance.</td>
</tr>
<tr>
<td>13% (16% WA)</td>
<td>WA early adopter of Obama’s affordable care act insurance. WGH has 7 trained enrolers to assist</td>
<td>WA early adopter of Obama’s affordable care act insurance. WGH has 7 trained enrolers to assist</td>
</tr>
<tr>
<td>Youth who report using marijuana in past</td>
<td>residents in attaining insurance.</td>
<td>residents in attaining insurance.</td>
</tr>
<tr>
<td>30 days 14% (20% WA).</td>
<td>WA early adopter of Obama’s affordable care act insurance. WGH has 7 trained enrolers to assist</td>
<td>WA early adopter of Obama’s affordable care act insurance. WGH has 7 trained enrolers to assist</td>
</tr>
<tr>
<td>NOTE, this data was from 2010 prior to WA</td>
<td>residents in attaining insurance.</td>
<td>residents in attaining insurance.</td>
</tr>
<tr>
<td>legalizing marijuana in 2013.</td>
<td>WA early adopter of Obama’s affordable care act insurance. WGH has 7 trained enrolers to assist</td>
<td>residents in attaining insurance.</td>
</tr>
<tr>
<td></td>
<td>residents in attaining insurance.</td>
<td>residents in attaining insurance.</td>
</tr>
</tbody>
</table>
## Example

<table>
<thead>
<tr>
<th>Services Provided:</th>
<th>Characteristics That Increase Risk</th>
<th>Characteristics that Decrease Risk</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical</td>
<td>State of Washington has cut beds and funding for mental health services, resulting in boarding ITA patients in the ED or hospital. Limited psychiatric outpatient care on the island.</td>
<td>Critical Care Access hospital centrally located in Coupeville. Hospitalist program. 4 general surgeons, 3 orthopedic surgeons. ED, OB, Peds care. Accredited sleep center. 2 rural health clinics, 2 family practice clinics, 1 general surgery clinic, 1 orthopedic clinic and 1 women’s health clinic owned by the hospital. Hospital owns home health and hospice as well as the EMS system. DI contains state of the art CT, MRI including breast MRI and stereotactic biopsy services. Ambulatory infusion clinic staff with oncologists from Providence Hospital on the mainland provides chemotherapy services.</td>
</tr>
</tbody>
</table>
Sources of Information for the Geographic and Population Assessment

- BRFSS: Behavioral Risk Factor Surveillance System (CDC)
  - WY coordinator: Joseph Grandpre, PhD, MPH
    Wyoming Department of Health
    Preventive Health and Safety Division
    6101 Yellowstone Road, Suite 510
    Cheyenne, Wyoming 82002
- CDC STD Report
- Healthy Youth Survey (WA)
- YRBSS: Youth Risk Behavior Risk Surveillance System
  - Youth online to access WY results
- Healthy People 2020
- US Dept of Commerce, Census Bureau
## Infection Control Prevention Risk Assessment
*(the excel handout)*

<table>
<thead>
<tr>
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</thead>
<tbody>
<tr>
<td>ABX resistant organisms</td>
<td>Expect It</td>
<td>Catastrophic Loss (Life/Limb/Function/Financial)</td>
<td>None</td>
<td>5</td>
</tr>
<tr>
<td>MRSA</td>
<td>Likely</td>
<td>Serious Loss (Function/Financial/Legal)</td>
<td>Poor</td>
<td>4</td>
</tr>
<tr>
<td>C Diff</td>
<td>Maybe</td>
<td>Prolonged Length of Stay</td>
<td>Fair</td>
<td>3</td>
</tr>
<tr>
<td>VRE</td>
<td>Rare</td>
<td>Moderate Clinical/Financial</td>
<td>Good</td>
<td>2</td>
</tr>
<tr>
<td>ESBL/other Gram Negative bacteria</td>
<td>Never</td>
<td>Minimum Clinical/Financial</td>
<td>Solid</td>
<td>1</td>
</tr>
<tr>
<td>Failure of Prevention Activities</td>
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<tr>
<td>Lack of Hand Hygiene</td>
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# Tour of the Risk Assessment Grid

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<tbody>
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<td>ABX resistant organisms</td>
<td></td>
<td>Expect It Likely Maybe Rare Never Catastrophic Loss (Life/Limb/Function/Financial) Serious Loss (Function/Financial/Legal) Prolonged Length of Stay Moderate Clinical/Financial Minimum Clinical/Financial None Poor Fair Good Solid</td>
<td></td>
<td></td>
</tr>
<tr>
<td>MRSA</td>
<td></td>
<td>4 3 2 1 0 5 4 3 2 1</td>
<td></td>
<td></td>
</tr>
<tr>
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<td></td>
<td>4 3 2 1 0 5 4 3 2 1</td>
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</tbody>
</table>

23
Sources of Information for the Grid

• Your historical data
• Reports in the literature
• APIC list serve
• Local meetings/peer groups
• Multidisciplinary team members
Conducting the Risk Assessment

• Multidisciplinary team
  – Employee health, environmental services, lab, pharmacy, nursing, administration etc.
• Perform at least annually
  – Remember to update if new services are added
• Review in infection control committee
• Organization determines scoring value below which no action plan is needed
• Organization/committee consensus for priorities
Purpose of Risk Assessment Grid

• Rank ordering risks by total score helps identify priorities
• Priorities are built into the infection prevention and control program plan
• Stratify infection risks
• Review prevention and control program plan with actual data for success or needed changes to the plan
# Let’s get started

<table>
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</thead>
<tbody>
<tr>
<td></td>
<td>Expect It</td>
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<td>ABX resistant organisms</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
</tr>
</tbody>
</table>

- ABX resistant organisms
- MRSA
- C Diff
- VRE
- ESBL/other Gram Negative bacteria
- CRE
## Failure of Prevention Activities

<table>
<thead>
<tr>
<th></th>
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<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Failure of Prevention Activities</td>
<td>Expect It</td>
<td>4</td>
<td>None</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td>Likely</td>
<td>3</td>
<td>Poor</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>Maybe</td>
<td>2</td>
<td>Fair</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Rare</td>
<td>1</td>
<td>Good</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Never</td>
<td>0</td>
<td>Solid</td>
<td>1</td>
</tr>
<tr>
<td>Lack of Hand Hygiene</td>
<td></td>
<td>5</td>
<td>None</td>
<td>5</td>
</tr>
<tr>
<td>Lack of Respiratory Hygiene/Cough Etiquette</td>
<td></td>
<td>4</td>
<td>Poor</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td></td>
<td>3</td>
<td>Fair</td>
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<td>Fair</td>
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<td>Good</td>
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<td></td>
<td></td>
<td>1</td>
<td>Solid</td>
<td>1</td>
</tr>
<tr>
<td>Antibiotic stewardship</td>
<td></td>
<td>5</td>
<td>None</td>
<td>5</td>
</tr>
<tr>
<td>Patient placement/cohorting</td>
<td></td>
<td>4</td>
<td>Poor</td>
<td>4</td>
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<td>Fair</td>
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</table>
# Isolation Activities

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</tr>
<tr>
<td></td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
</tr>
</tbody>
</table>

**Isolation Activities**

**Lack of Standard Precautions**

**Lack of Airborne Precautions**

**Lack of Droplets Precautions**

**Lack of Contact Precautions**
### Policy and Procedures

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<tbody>
<tr>
<td>Expect It</td>
<td>Likely</td>
<td>Maybe</td>
<td>Rare</td>
</tr>
</tbody>
</table>

- Lack of current policies or procedures (specify)
- Failure to follow established policy or procedure (specify)
# Healthcare Acquired Infections

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</thead>
<tbody>
<tr>
<td>Expect It Likely Maybe Rare Never</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Catastrophic Loss (Life/Limb/Function/Financial)</td>
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<tr>
<td>Serious Loss (Function/Financial/Legal)</td>
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<td></td>
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<tr>
<td>Prolonged Length of Stay</td>
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<td></td>
</tr>
<tr>
<td>Moderate Clinical/Financial</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Minimum Clinical/Financial</td>
<td>None Poor Fair Good Solid</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>None Poor Fair Good Solid</td>
<td></td>
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</tr>
</tbody>
</table>

## Healthcare Acquired Infections

- Surgical Site Infections (SSI) Cardiac
- SSI - Orthopedic Joint Replacement
- SSI - C-Section
- SSI - Other
- VAP in ICUs
- CLR-BSI in ICUs
- CLR-BSI - House wide
- Dialysis-Related Infections
- Fungal Pneumonia
- Norovirus
- CA-UTI
- Outbreak
- Sentinel Event
- Other - HAI
- Other - HAI
## Employee Health and “Other”

<table>
<thead>
<tr>
<th>Potential Risks/ Problems</th>
<th>Probability</th>
<th>Risk/Impact (Health, Financial, Legal, Regulatory)</th>
<th>Currrent Systems/Preparedness</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Expect It</td>
<td>4</td>
<td>5</td>
<td></td>
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<td>Minimum Clinical/Financial</td>
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### Lack of Staff Influenza Immunization

### Other

### Risk of Community Outbreak
Setting Priorities
## Rank order of the Scores

<table>
<thead>
<tr>
<th>Item</th>
<th>Probability</th>
<th>Risk/Impact</th>
<th>Current Systems</th>
<th>SCORE</th>
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<tr>
<td>MRSA</td>
<td>4</td>
<td>4</td>
<td>3</td>
<td>48</td>
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<td>Community outbreak, pertussis</td>
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<td>3</td>
<td>36</td>
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<td>C diff</td>
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<td>Fail to follow policies</td>
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<td>Lack of staff influenza vaccination</td>
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<td>Lack of hand hygiene</td>
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<td>Item</td>
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<td>Risk/Impact</td>
<td>Current Systems</td>
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<td>Contact precautions</td>
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<td>SSI in a total joint</td>
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<td>4</td>
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<td>Standard precautions</td>
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<td>Policies &amp; procedures</td>
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See handout titled “Whidbey General Hospital Infection Control & Prevention Progress Report”

<table>
<thead>
<tr>
<th>Priority #</th>
<th>Priority</th>
<th>Goal</th>
<th>Objective</th>
<th>Strategies</th>
<th>Progress/Analysis</th>
<th>Evaluation</th>
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</table>
# Goals and Objectives

<table>
<thead>
<tr>
<th>Meanings</th>
<th>Goal</th>
<th>Objective</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Meaning</strong></td>
<td>The purpose toward which an endeavor is directed.</td>
<td>Something that one's efforts or actions are intended to attain or accomplish; purpose; target.</td>
</tr>
<tr>
<td><strong>Example</strong></td>
<td>I want to achieve success in the field of genetic research and do what no one has ever done.</td>
<td>I want to complete this thesis on genetic research by the end of this month.</td>
</tr>
<tr>
<td><strong>Action</strong></td>
<td>Generic action, or better still, an outcome towards which we strive.</td>
<td>Specific action - the objective supports attainment of the associated goal.</td>
</tr>
<tr>
<td><strong>Measure</strong></td>
<td>Goals may not be strictly measurable or tangible.</td>
<td>Must be measurable and tangible.</td>
</tr>
<tr>
<td><strong>Time frame</strong></td>
<td>Longer term</td>
<td>Mid to short term</td>
</tr>
</tbody>
</table>

- **Goals**: The purpose toward which an endeavor is directed.
- **Objectives**: Something that one's efforts or actions are intended to attain or accomplish; purpose; target.
- **Meaning**:
  - Generic action, or better still, an outcome towards which we strive.
  - Goals may not be strictly measurable or tangible.
  - Longer term
- **Example**:
  - I want to achieve success in the field of genetic research and do what no one has ever done.
  - I want to complete this thesis on genetic research by the end of this month.

**References**: The purpose toward which an endeavor is directed. Something that one's efforts or actions are intended to attain or accomplish; purpose; target.
Objectives, Strategies and Tactics

- Strategies are action plans to achieve the objective
- Strategies are the *HOW*
- Tactics are specific action steps to deliver on a strategy
- Tactics are a *WHAT*
<table>
<thead>
<tr>
<th>Priority #</th>
<th>Priority</th>
<th>Goal</th>
<th>Objective</th>
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<tr>
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<td>MRSA (score 48)</td>
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<tr>
<td></td>
<td>Pertussis outbreak (36)</td>
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<tr>
<td></td>
<td>C diff (32)</td>
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<td></td>
<td>Fail to follow policies (16)</td>
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<td>Staff influenza vaccination (16)</td>
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<td>Lack of hand hygiene</td>
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<td></td>
<td>Contact precautions (10)</td>
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<td></td>
<td>SSI in a total joint (8)</td>
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<td>Standard precautions (8)</td>
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<td></td>
<td>Policies &amp; procedures (4)</td>
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</table>
## Program Plan & Progress Report

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<th>Priority</th>
<th>Goal</th>
<th>Objective</th>
<th>Strategies</th>
<th>Progress/Analysis</th>
<th>Evaluation</th>
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<tbody>
<tr>
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<td>MRSA (score 48)</td>
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<td>2</td>
<td>Pertussis outbreak (36)</td>
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<td>3</td>
<td>C diff (32)</td>
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<td>Contact precautions (10)</td>
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<td>Standard precautions (8)</td>
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<td>Policies &amp; procedures (4)</td>
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## MRSA (score 48)

<table>
<thead>
<tr>
<th>Goal</th>
<th>Objective</th>
<th>Strategies</th>
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</thead>
</table>
| Prevent the transmission of MRSA | Conduct a MRSA risk assessment by___ | Risk assessment will include:  
1. Proportion of *S. aureus* isolates resistant to methicillin  
2. MRSA colonization incidence  
3. MRSA infection incidence such as bacteremia  
4. Point prevalence survey of MRSA colonization or infection |
| Implement MRSA monitoring program by ____ | 1. Test adult (ICU) patients within 24 hours of admission, unless the person has already been tested during that stay or has a known history of MRSA (WA state law)  
2. Track pts + for MRSA for isolation on subsequent visits  
3. Daily review of lab results  
4. Regular reporting of MRSA rates to stakeholders including Sr Leadership & Board  
5. External reporting to WA DOH |
## MRSA

<table>
<thead>
<tr>
<th>Goal</th>
<th>Objective</th>
<th>Strategies</th>
</tr>
</thead>
</table>
| Prevent the transmission of MRSA | Institute Prevention Practices by ____ | 1. Test and decolonize prospective total joint surgical candidates  
2. Provide decolonization therapy to MRSA colonized pts in conjunction with ICU active surveillance  
3. Monitor and ensure hand hygiene compliance  
4. Ensure compliance with contact precautions  
5. Ensure proper disinfection of shared patient equipment  
6. Use dedicated pt equipment for MDRO + pts  
7. Bathe ICU pts with CHG  
8. Institute MRSA room assignment consent form (WA state law)  
9. Written & verbal education to pt about after care & prevention of spreading (WA state law) |
## Pertussis Community Outbreak (score 36)

<table>
<thead>
<tr>
<th>Priority</th>
<th>Goal</th>
<th>Objective</th>
<th>Strategies</th>
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</thead>
</table>
| Pertussis outbreak| Decrease morbidity and mortality among infants | Initiate active surveillance for pertussis & continue for at least 42 days after cough onset of last case | 1. Alert ED and clinics about the outbreak  
2. Educate providers on signs & symptoms, DX, TX & reporting of cases  
3. Encourage Peds, OB, L&D to emphasize importance of keeping infants <1 away from individuals with a cough illness  
4. Send periodic pertussis alerts to ED and clinics  
5. Cases- ABT as soon as pertussis is suspected in pt or HCW  
6. Contacts- if highly suspected in a pt, chemoprophylaxis for all close contacts & high risk contacts |
## Pertussis Community Outbreak

<table>
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<th>Priority</th>
<th>Goal</th>
<th>Objective</th>
<th>Strategies</th>
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<tr>
<td>Pertussis outbreak</td>
<td>Decrease morbidity and mortality among infants</td>
<td>Initiate active prevention program by _</td>
<td>1. OB clinic- improve rates of TDAP vaccination among pregnant women</td>
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<td></td>
<td>3. Droplet precautions in ED and inpatient</td>
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<td></td>
<td>4. Screen visitors for S&amp;S</td>
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<td>5. Educate visitors on PPE</td>
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<td>6. Ensure adequate PPE supplies on isolation cart</td>
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## C diff (score 32)

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<tr>
<th>Priority</th>
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<th>Objective</th>
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</thead>
</table>
| C diff   | Reduce the rate of C diff hospitalizations 30%. Current data is 13.6 hospitalizations per 1000 discharges. | Assess implementation of practices that potentially reduce C diff | 1. Monthly surveillance for hospital wide C diff rates  
2. Testing for toxins A & B  
3. Immediate notification to unit by lab with + results  
4. Use of contact precautions  
5. Adherence to soap & water hand washing  
6. Environmental cleaning with hypochlorite based disinfectant each occupied day  
7. Terminal clean with hypochlorite based disinfectant on discharge  
8. Dedicated pt equipment  
9. Use of EPA approved disinfectant to clean common equipment like wheelchairs |
### C diff

<table>
<thead>
<tr>
<th>Priority</th>
<th>Goal</th>
<th>Objective</th>
<th>Strategies</th>
</tr>
</thead>
</table>
| C diff   | Reduce the rate of C diff hospitalizations 30%. Current data is 13.6 hospitalizations per 1000 discharges. | Assess implementation of practices that potentially reduce C diff | 11. Policy/protocol for treatment of C diff  
12. Antibiotic stewardship in treatment of CDI  
13. Flag placed in EMR  
14. ATP/glow germ to test room cleanliness quarterly with Environmental Services and IP  
15. Monthly unit dashboards containing infection data disseminated to front line staff and leadership  
16. Best practice certificates given to units that are high performers  
17. Pt and family/caregiver education |
## SSI in a total joint (score 8)

<table>
<thead>
<tr>
<th>Goal</th>
<th>Objective</th>
<th>Strategies</th>
</tr>
</thead>
</table>
| Zero SSI in total hip and knee arthroplasty | Reduce incidence and consequences of SSI in total joint from ___ to ___ by___ | 1. Continue focused surveillance for SSI  
2. Revise post discharge surveillance to include post discharge call to pt asking specific questions r/t signs of infection  
3. Report SSI data to Chief of Surgery, OR Governance, Quality Com, Sr Leadership, surgeons.  
4. Assess current process & reliability of each best practice to determine areas in most need of improvement. (goal is 95% or >)  
5. Monitor SCIP measures for 100% compliance  
6. 3 days prior to surgery, instruct pt to bathe with CHG daily  
7. Screen pts for *Staph aureus* & decolonize SA carriers with 5 days of intranasal mupirocin  
8. OR rounds and IP monitoring of skin prep |
You Can’t Do It All At Once!
And you can’t do it alone...

• Set quarterly priorities
• Note what has been assigned and/or delegated to others
• Update your plan in the Infection Prevention Committee meeting
  – Progress
  – Challenges
  – Barriers
## Re-visiting the Plan

<table>
<thead>
<tr>
<th>Goal</th>
<th>Objective</th>
<th>Strategies</th>
</tr>
</thead>
</table>
| Prevent the transmission of MRSA | Conduct a MRSA risk assessment by **Quarter 1, 2014. Infection Preventionist.** | Risk assessment will include:  
1. Proportion of *S. aureus* isolates resistant to methicillin  
2. MRSA colonization incidence  
3. MRSA infection incidence such as bacteremia  
4. Point prevalence survey of MRSA colonization or infection |
| Implement MRSA monitoring program by **Quarter 1, 2014. Infection Preventionist.** | 1. Test adult (ICU) patients within 24 hours of admission, unless the person has already been tested during that stay or has a known history of MRSA (WA state law)  
2. Track pts + for MRSA for isolation on subsequent visits  
3. Daily review of lab results  
4. Regular reporting of MRSA rates to stakeholders including Sr Leadership & Board  
5. External reporting to WA DOH |
<table>
<thead>
<tr>
<th>Goal</th>
<th>Objective</th>
<th>Strategies</th>
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</thead>
<tbody>
<tr>
<td>Prevent the transmission</td>
<td>Institute Prevention Practices by Quarter 2, 2014</td>
<td>1. Test and decolonize prospective total joint surgical candidates. Pre-op assessment RN with Ortho</td>
</tr>
<tr>
<td>of MRSA</td>
<td></td>
<td>2. Provide decolonization therapy to MRSA colonized pts in conjunction with ICU active surveillance. Ortho Clinic</td>
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<tr>
<td></td>
<td></td>
<td>3. Monitor and ensure hand hygiene compliance Hand Hygiene Team</td>
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<td>4. Ensure compliance with contact precautions IP, Nsg. Daily rounding.</td>
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<td>5. Ensure proper disinfection of shared patient equipment. Nsg</td>
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<td>6. Use dedicated pt equipment for MDRO + pts Nsg</td>
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<td>7. Bathe ICU pts with CHG Nsg</td>
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<td>8. Institute MRSA room assignment consent form (WA state law) Pt Access, IP</td>
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<td>9. Written &amp; verbal education to pt about after care &amp; prevention of spreading (WA state law). IP develops, Nsg Provides</td>
</tr>
<tr>
<td>Priority</td>
<td>Goal</td>
<td>Objective</td>
</tr>
<tr>
<td>--------------------------</td>
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<td>---------------------------------------------------------------------------</td>
</tr>
</tbody>
</table>
| Pertussis outbreak       | Decrease morbidity and mortality among infants | Initiate active surveillance for pertussis & continue for at least 42 days after cough onset of last case. NOW! | 1. Alert ED and clinics about the outbreak. IP  
2. Educate providers on signs & symptoms, DX, TX & reporting of cases. IP, ED Med Director, Chief of Staff  
3. Encourage Peds, OB, L&D to emphasize importance of keeping infants <1 away from individuals with a cough illness. IP, Chief of Medicine  
4. Send periodic pertussis alerts to ED and clinics IP  
5. Cases- ABT as soon as pertussis is suspected in pt or HCW. Providers  
6. Contacts- if highly suspected in a pt, chemoprophylaxis for all close contacts & high risk contacts. Providers, Occ Health |
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<tr>
<td>Pertussis outbreak</td>
<td>Decrease morbidity and mortality among infants</td>
<td>Initiate active prevention program by NOW!</td>
<td>1. OB clinic- improve rates of TDAP vaccination among pregnant women <strong>OB Providers</strong></td>
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<tr>
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<td>2. Monitor compliance with respiratory/cough etiquette. <strong>Nursing Practice Council</strong></td>
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<td>3. Droplet precautions in ED and inpatient <strong>Nursing</strong></td>
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<td>4. Screen visitors for S&amp;S <strong>Volunteers &amp; Pt Access</strong></td>
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<td>5. Educate visitors on PPE <strong>PR</strong></td>
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<td>6. Ensure adequate PPE supplies on isolation cart <strong>Central Supply</strong></td>
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<tr>
<td>Priority</td>
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<td>Objective</td>
<td>Strategies</td>
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</tbody>
</table>
| C diff   | Reduce the rate of C diff hospitalizations 30%. Current data is 13.6 hospitalizations per 1000 discharges By Jan 1, 2015 | Assess implementation of practices that potentially reduce C diff By Quarter 1, 2014 | 1. Monthly surveillance for hospital wide C diff rates IP  
2. Testing for toxins A & B Lab  
3. Immediate notification to unit by lab with + results Lab  
4. Use of contact precautions Nsg, IP daily rounds  
5. Adherence to soap & water hand washing Hand Hygiene Team, IP  
6. Environmental cleaning with hypochlorite based disinfectant each occupied day IP informs Env Services  
7. Terminal clean with hypochlorite based disinfectant on discharge Env Services  
8. Dedicated pt equipment Nsg  
9. Use of EPA approved disinfectant to clean common equipment like wheelchairs Env Services |
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<td>Assess implementation of practices that potentially reduce C diff</td>
<td>11. Policy/protocol for treatment of C diff IP, Chief of Medicine</td>
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<tr>
<td></td>
<td>hospitalizations per 1000 discharges. By Jan 1, 2015</td>
<td>By Quarter 1, 2014</td>
<td>12. Antibiotic stewardship in treatment of CDI QR Med Director, Pharm Director, Lab Mgr, MEC</td>
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<td>13. Flag placed in EMR IP</td>
</tr>
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<td>14. ATP/glow germ to test room cleanliness quarterly with Environmental Services and IP Env Svs &amp; IP</td>
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<td></td>
<td>15. Monthly unit dashboards containing infection data disseminated to front line staff and leadership IP w/ QR</td>
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<td>16. Best practice certificates given to units that are high performers IP</td>
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<td>17. Pt and family/caregiver education IP develops, Nsg provides</td>
</tr>
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</table>
| Zero SSI in total hip and knee arthroplasty | Reduce incidence and consequences of SSI in total joint from ___ to ___ by Quarter 4, 2014 | 1. Continue focused surveillance for SSI IP  
2. Revise post discharge surveillance to include post discharge call to pt asking specific questions r/t signs of infection IP, maybe Care Mgt calls the pt  
3. Report SSI data to Chief of Surgery, OR Governance, Quality Com, Sr Leadership, surgeons IP  
4. Assess current process & reliability of each best practice to determine areas in most need of improvement. (goal is 95% or >) IP  
5. Monitor SCIP measures for 100% compliance QR w/IP  
6. 3 days prior to surgery, instruct pt to bathe with CHG daily Pre-op Nurse  
7. Screen pts for *Staph aureus* & decolonize SA carriers with 5 days of intranasal mupirocin Ortho Clinic  
8. OR rounds and IP monitoring of skin prep IP, OR Mgr monthly |
Keeping It Realistic, Q 1 for IP

1. Alert ED and clinics about the Pertussis outbreak. IP
2. Educate providers on Pertussis signs & symptoms, DX, TX & reporting of cases. IP, ED Med Director, Chief of Staff
3. Encourage Peds, OB, L&D to emphasize importance of keeping infants <1 away from individuals with a cough illness. IP, Chief of Medicine
4. Send periodic Pertussis alerts to ED and clinics IP
5. Conduct MRSA risk assessment IP
6. Implement MRSA monitoring program IP
7. Daily rounding to ensure compliance with contact precautions IP, Nsg
8. Monthly surveillance for hospital wide C diff rates IP
9. Adherence to soap & water hand washing Hand Hygiene Team, IP
10. Policy/protocol for treatment of C diff IP, Chief of Medicine
11. C diff Flag placed in EMR IP
12. ATP/glow germ to test room cleanliness quarterly Env Svs & IP
13. Monthly unit dashboards containing infection data disseminated to front line staff and leadership IP w/ QR
14. Best practice certificates given to units that are high performers IP
15. Pt and family/caregiver education IP develops, Nsg provides
Keeping It Realistic, Q 2 for IP

1. Institute MRSA room assignment consent form (WA state law) Pt Access, IP
2. Written & verbal education to pt about after care & prevention of spreading (WA state law). IP develops in Q2, Nsg Provides
3. Continue focused surveillance for SSI IP
4. Revise post discharge surveillance to include post discharge call to pt asking specific questions r/t signs of infection IP in Q2, maybe Care Mgt calls the pt starting Q3
5. Report SSI data to Chief of Surgery, OR Governance, Quality Com, Sr Leadership, surgeons IP
6. Assess current process & reliability of each best practice to determine areas in most need of improvement. (goal is 95% or >) IP
7. Monitor SCIP measures for 100% compliance QR w/IP
8. OR rounds and IP monitoring of skin prep IP, OR Mgr monthly
Working Through Others
supported by the CMS Worksheet & Regs

• 1. B.1 The Infection Control Officer(s) can provide evidence that problems identified in the infection control program are addressed in the hospital QAPI program (i.e., development and implementation of corrective interventions, and ongoing evaluation of interventions implemented for both success and sustainability).

• 1. B.3 Hospital leadership, including the CEO, Medical Staff, and the Director of Nursing Services ensures the hospital implements successful corrective action plans in affected problem area(s).
Working Through Others
supported by APIC’s Competency Model

• “IP’s leadership is based on influence rather than authority, and this influence is a consequence of skills in the 5 content categories
  – Collaboration
  – Followership
  – Program Management
  – Critical thinking skills
  – Communication

Murphy, D. et al. AJIC 40 (2102) 296-303
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<td>Conduct a MRSA risk assessment by Quarter 1, 2014. Infection Preventionist.</td>
<td>Risk assessment will include: 1. Proportion of <em>S. aureus</em> isolates resistant to methicillin 2. MRSA colonization incidence 3. MRSA infection incidence such as bacteremia 4. Point prevalence survey of MRSA colonization or infection</td>
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## Progress/Analysis

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<tr>
<td>MRSA</td>
<td>Risk assessment will include:</td>
<td></td>
</tr>
<tr>
<td></td>
<td>1. Proportion of <em>S. aureus</em> isolates resistant to methicillin</td>
<td>Q1: Assessment completed 3/2014. 50% of <em>S. aureus</em> isolates are methicillin resistant. No MRSA HAI this quarter. Point prevalence results, 15% of adult admissions on 2/24/14 were MRSA +, of which 98% were previously known and were already in contact isolation. Share results with Nsg to stress importance of standard precautions and hand hygiene.</td>
</tr>
<tr>
<td></td>
<td>2. MRSA colonization incidence</td>
<td></td>
</tr>
<tr>
<td></td>
<td>3. MRSA infection incidence such as bacteremia</td>
<td></td>
</tr>
<tr>
<td></td>
<td>4. Point prevalence survey of MRSA colonization or infection</td>
<td></td>
</tr>
<tr>
<td></td>
<td>1. Test adult (ICU) patients within 24 hours of admission, unless the person has already been tested during that stay or has a known history of MRSA (WA state law)</td>
<td>Q1: State mandated MRSA ICU testing and reporting in place. See attached chart for MRSA rates.</td>
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<tr>
<td></td>
<td>2. Track pts + for MRSA for isolation on subsequent visits</td>
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<td>3. Daily review of lab results</td>
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<td></td>
<td>4. Regular reporting of MRSA rates to stakeholders including Sr Leadership &amp; Board</td>
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<td></td>
<td>5. External reporting to WA DOH</td>
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</tr>
<tr>
<td>Date</td>
<td>Pts tested</td>
<td>Pts Positive</td>
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</tr>
<tr>
<td>Jan</td>
<td>3</td>
<td>1</td>
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<tr>
<td>Feb</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>March</td>
<td>4</td>
<td>1</td>
</tr>
<tr>
<td>April</td>
<td>1</td>
<td>0</td>
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**ICU Patients, Percent MRSA Positive on Admission 2014**

![Graph showing percent positive MRSA positive on admission from January to April 2014](image)
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| C. diff  | 1. Monthly surveillance for hospital wide *C diff* rates IP  
2. Testing for toxins A & B Lab  
3. Immediate notification to unit by lab with + results Lab  
4. Use of contact precautions Nsg, IP daily rounds  
5. Adherence to soap & water hand washing Hand Hygiene Team, IP  
6. Environmental cleaning with hypochlorite based disinfectant each occupied day IP informs Env Services | **Q1:** Surveillance in process. See attached chart.  
Lab alert written & populates nurse’s work list.  
IP daily rounds in March showed decrease in compliance with signs & 3 pts were not isolated. 1:1 education provided.  
Bed board rule written to alert Env Svs of *C. diff* rooms for bleach cleaning. |
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6. 3 days prior to surgery, instruct pt to bathe with CHG daily Pre-op Nurse  
7. Screen pts for *Staph aureus* & decolonize SA carriers with 5 days of intranasal mupirocin Ortho Clinic  
8. OR rounds and IP monitoring of skin prep IP, OR Mgr monthly | Q1 increase in superficial incisional infections in total knees. All of the infections were a locum surgeon’s. See chart. ABT timing ranging from 85-95% compliance due to lack of on time delivery from pharmacy. ABT ordering & delivery process reviewed with Pharm. Post discharge surveillance call sheet developed. |
Percent Superficial Infections, Total Knee 2013-2014

Locum Surgeon

Percent Superficial
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Q2 No superficial incisional infections in total knees. Zero deep infections for hips and knees continues. SCIP measures at 100%. OR rounds noted lack of proper OR attire (masks below the nose, hair not contained). Education in OR staff mtg.  
Q3 Care management implemented post discharge surveillance tool. 75 calls completed /145 surgical patients (52%). Q4 goal set at 75%.  
Q4 New orthopedic surgeon hired. SCIP composite score dropped from 100% to 95%. Chief of Surgery addressed in OR Governance. Individual non-compliance will be sent to peer review. |
Evaluation
### Moving to the Evaluation Section

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Lab alert written & populates nurse’s work list.  
IP daily rounds in March showed decrease in compliance with signs & 3 pts were not isolated (compliance at 80%). 1:1 education provided.  
Bed board rule written to alert Env Svs of \textit{C. diff} rooms for bleach cleaning.  
**Q2** Compliance with contact precautions remains inconsistent. Staff observed not gowning & gloving to enter room. Nsg states they don’t have time to restock the carts.  
**Q3** Env Serv stocking carts. Contact precautions compliance improved to 95%. 2 pts were not isolated, lab did not alert IP or Nsg of + test.  
**Q4** ABT Stewardship CME given. \textit{C diff} rate 13/10,000 pt days. |
Evaluation

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<td><strong>Q1</strong> Contact precaution daily surveillance during IP rounds continues. <strong>Q2</strong> PIP team launched to address stocking isolation carts. <strong>Q3</strong> Contact precaution compliance improving with Env Svs stocking carts. Glitch in lab module resulted in alerts not being sent to nurses’ work lists. Lab changed parameters and did not use change control process. Correction now complete. <strong>Q4</strong> C diff rate remains high, 13,10,000 pt days. ABT stewardship CME given. Chief of Medicine agreed to charter PIP addressing unnecessary ABT.</td>
</tr>
<tr>
<td><strong>Q2</strong> Compliance with contact precautions remains inconsistent. Staff observed not gowning &amp; gloving to enter room. Nsg states they don’t have time to restock the carts.</td>
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<td><strong>Q3</strong> Env Serv stocking carts. Contact precautions compliance improved to 95%. 2 pts were not isolated, lab did not alert IP or Nsg of + test.</td>
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<td><strong>Q4</strong> ABT Stewardship CME given. C diff rate 13/10,000 pt days.</td>
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High Reliability in Healthcare

• Method to ensure pt safety and quality of care
  – Based on system design
  – Technical skills and Non-technical skills
• Defined as defect free operations for long periods of time
• High reliability organizations implement specific training to minimize errors
Model for High Reliability Teams

High Reliability = Technical skills + non-technical skills + process design

Technical skills
- Training
- Competence
- Commitment to education and certification

Non-Technical skills
- Cognitive
- Interpersonal competencies
- Monitoring team performance
- Knowledge of team roles
- Positive attitude

Culture of Safety
High Reliability Teams

Culture of Safety

High Reliability = Technical skills + non-technical skills + process design

Failure of team work
Failure of communication
Failure of process design
High Performing Teams

• Behavioral markers
  – Establishing leadership
  – Situational awareness
  – Closed loop communication
  – Shared mental model
Organizational Learning

• Successful organizations
  – Define learning agenda based on their knowledge gaps
  – Open to discordant information
  – Reports are trusted because relationships and reporting systems are healthy
  – Avoid repeated mistakes
    • Reflect on experience, distill lessons, share the knowledge and refine the process
  – Knowledge is common property
To Learn

• One must be humble. No one person knows it all
• Learning demands openness
• Everyone needs to be willing to challenge assumptions
  – Think more deeply
• Leaders create supportive learning environment
  – Move from “this is the way we have always done it”
  – Accept occasional failures and mistakes as the price of improvement
• Pressure alone does not produce creative and innovative thinking or solutions
Safe Culture/Just Culture

• Encourage staff to reveal/report mistakes
• Near misses are our free lessons
  – Reveal potential dangers
  – Warning signals to exposure of vulnerability
  – Take time to learn from them
• Celebrate the good catch
• Fix the system/process issues instead of a fixing blame
  – Freedom to fail should not be confused with a license to commit foolish mistakes
No “Simple” Explanations

• High reliability organizations are reluctant to accept the simple explanation for problems

• Some simple explanations
  – Poor communication
  – Staffing shortages
  – Limited resources

• Dig deeper, the explanation may be under the superficial one
Percent Superficial Infections, Total Knee 2013-2014

- Locum Surgeon

No orientation to our processes
He hurried the OR staff= inadequate skin prep
ABT not on time
Doesn’t believe in pre-op antiseptic showering
Quality Focused Culture

- Culture is a consensus view of the way we do things
- Leverages the knowledge, skills and expertise of healthcare workers
  - To develop methods and strategies to improve healthcare and patient safety
- Employs multidisciplinary teams
  - Increased creativity for problem solving
  - Increased acceptance of solutions
  - Improved productivity
  - Positive impact on morale
  - Helps align work with organization mission, vision and values
Tools for Performance Improvement

- Gap analysis
- Goal directed checklists
- Fishbone “Ishikawa”
- Resources for a variety of tools
  - www.asq.org
    - Seven basic quality tools
    - Project planning tools
    - Go to knowledge center and click on tools tab
Gap Analysis

• Helps to move from current state to desired state
• Identifies gaps that exist between current processes and new standard
• Team takes steps to fill the gaps
# Gap Analysis Tool

<table>
<thead>
<tr>
<th>Future State</th>
<th>Current Situation</th>
<th>Next Actions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Foley catheters will be discontinued within post op day 1 or 2 with day of surgery being day zero</td>
<td>90% of Foley catheters are discontinued after 54 hours post op.</td>
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</table>
Quality Tools Resources

• AHRQ Quality Indicators Toolkit
  – AHRQ Tool Kit for Hospitals
    • Outlines steps for improvement with toolkit roadmap
  – Gap Analysis Tool (Tool D.5)
  – Implementation Plan (Tool D.6)

Gap Analysis Tool
Project:
Best Practice:
Individual completing form:

<table>
<thead>
<tr>
<th>Best Practice</th>
<th>Best Practice Strategies</th>
<th>How your practice differs from best practice</th>
<th>Barriers to best practice implementation</th>
<th>Implement best practice? Y/N? Why not?</th>
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**Implementation Plan**

**Project:**

**Individual completing this form:**

<table>
<thead>
<tr>
<th>Best Practice from Gap Analysis</th>
<th>Detailed Tasks/Action associated with implementation</th>
<th>Team member assigned to each task</th>
<th>Target completion date</th>
<th>Actual completion date</th>
<th>Communication/Training required? Y/N</th>
<th>Communication/Training schedule date</th>
<th>Communication/Training completion date</th>
<th>Go Live Date</th>
<th>Project completed? Y/N</th>
</tr>
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Goal Directed Checklists

• Follows aviation model
• Helps with memory recall
• Makes explicit the steps to complete complex procedures
• Incorporates evidence based quality parameters
• Bundles- VAP, Sepsis, Central line insertion, Bladder
Checklist Resources

• Atul Gawande: *Checklist Manifesto: How to get Things Right*
• Peter Pronovost: *Safe Patients, Smart Hospitals*
• AHRQ Central Line Insertion Care Team Checklist at [www.ahrq.gov/qual/clichklist.htm](http://www.ahrq.gov/qual/clichklist.htm)
• Safer ICUs Eliminating CLABSI Collaborative Project Management Task list at [www.ncqualitycenter.org](http://www.ncqualitycenter.org)
Outcome & Process Measures
Outcome Measures

• These measures tell you whether changes are actually leading to improvement
• Examples of outcome measures:
  – Adverse Drug Events (ADEs) per 1,000 Doses
  – Number of Cases between Surgical Site Infections.
What are process measures?

• To affect the outcome measure of improving patient safety, you will make changes to improve many core processes

• Measuring the results of these process changes will tell you if the changes are leading to an improved, safer system

• Examples include:
  – Percentage of Staff Reporting a Positive Safety Climate
  – Pharmacy Interventions per 100 Admissions
  – Percent of Surgical Cases with On-Time Prophylactic Antibiotic Administration
  – Compliance with a bundle
We need both measures

• Outcome and process measures need to be balanced
  – to make sure that changes to improve one part of the system aren’t causing new problems in other parts of the system

• Example:
  – Glucose protocol, monitor compliance with new order set (process) and hypo/hyperglycemic events (outcomes)
Measures

• **Process Measure**
  - Foley catheter d/c within 24 hours of surgery
  - Percent compliance with central line insertion checklist

• **Outcome Measure**
  - CAUTI rate in surgical patients
  - CLABSI rate
Customer driven strategic planning
Goal setting
Resource planning
Annual performance planning
Resource allocation

Performance measurement goals

Customer & Stakeholder input
Management Priorities/Decisions

Performance reporting to customers/stakeholders

Evaluate and utilize performance information
Analyze and review data
Data collection and reporting
Establish accountability
Performance Improvement
Performance Improvement
Methodologies: PDSA or PDCA

• Plan, Do, Study, Act
• Plan
  – Identify goals, available resources and actions or steps to take
• Do
  – Implement the activities or steps identified
• Study or Check
  – Analyze data, benchmark, trend data
• Act
  – Based on analysis redefine actions or steps to take to achieve the goal
  – Continuous cycle
Six Sigma

• Define a problem or improvement opportunity
• Measure process performance
• Analyze the process and determine the root causes of poor performance and if the process can be improved or redesigned
• Improve the process
• Control the improved process to hold the gains
Performance Improvement
Methodologies: CUSP and TRIP

• CUSP
  – Comprehensive Unit based Safety Program

• TRIP
  – Translating Research into Practice

• CUSP and TRIP are a two pronged approach to performance improvement

• Both will be discussed in more detail in the following slides
Performance Improvement
Methodologies: CUSP

• Comprehensive unit based safety program
• Aim is changing the culture of safety
• Provides a framework for addressing patient safety issues at a local level
• Leverages local wisdom to identify potential patient harm and create individualized solutions
• Strengthens communication and collaboration at all levels of the organization senior leaders to front line staff
CUSP Framework

Create a culture of safety

- Train staff in science of safety
- Engage Staff to identify defects
- Senior executive partnership
- Learn from a defect
- Implement tools for improvement
Conduct literature search and identify best practices

  – Review of the impact of catheter duration. Patients with catheters removed earlier had decreased risk of infection,

  For med surg inpatient wards:
  – CAUTI rate pooled mean 1.5 (median percentile 0.8)
  – Foley DUR pooled mean 0.19 (median 0.18, top decile 0.10)
Using CUSP to Decrease CAUTI

• Gather unit specific data for the team
  – Review culture survey results
  – Review CAUTI rate
  – Review Foley utilization ratio
Using Your Data: learn from a defect

• Evaluate your CAUTI rate and compare to the NHSN tables
  – Is your rate above or below the 50th percentile (median) [1.5 per 1000 Foley days]
    • 50th percentile: 50% of the hospitals have rates lower than the median and 50% are higher
  – If you are above the median, are you at or above the 75th percentile?
    • 75% of the hospitals have rates lower than yours

• Evaluate your Foley DUR
  – If your CAUTI rate is high and our DUR is high your team may want to consider decreasing the duration of catheterization and the unnecessary use of catheters

Create a culture of safety
Train staff in science of safety
Engage Staff to identify defects
Senior executive partnership
Learn from a defect
Implement tools for improvement
Implement tools for improvement: ideas

- Develop criteria for Foley catheter indications
- Document alternative methods tried for bladder emptying prior to use of indwelling catheter
- Create a daily patient safety checklist
  - Assess and document why Foley is still in place
    - Each day a Foley is in the risk of CAUTI increases 5%
- Create a nurse driven protocol to d/c Foley without physician order
- Engage the staff, educate the staff, execute the interventions, evaluate results
- Monitor CAUTI rates
- Team review infected patient’s chart and share results of review with staff
TRIP: Translating Research into Practice

- Summarize the evidence
- Identify local barriers to implementation
- Measure performance
- Ensure all patients receive the interventions

Ensure all patients receive the interventions: Implement the 4 Es and target key stakeholders

- **Engage**
  Explain why the interventions are important

- **Educate**
  Share the evidence supporting the interventions

- **Execute**
  Design an intervention tool kit targeted at barriers, standardization, independent checks, reminders and learning from mistakes

- **Evaluate**
  Regularly assess for performance measures and unintended consequences
TRIP Lessons Learned

• The strong support of senior management increases the success

• Effective clinical leadership speeds adoption

• Data to support start-up, implementation, and ongoing evaluation must be credible and persuasive to those who influence budget decisions

• The speed of adoption is influenced by the degree to which the innovation requires changes in organizational culture

• The diffusion process is slowed when the effort requires coordination across departments or disciplines

• The perceived ability of an innovation to reduce external threats can influence the speed of its diffusion
Engage, Educate, Execute, Evaluate

• Resources
  – APIC’s Elimination Guides
Using Data to Evaluate Improvements

• Quality improvement cycle is never ending
  – It is a process not an event

• Data and analysis go on your IPCP Plan and Annual Report

• Data will be the foundation of next year’s risk assessment

![PDCA Cycle Diagram](image-url)
Evaluating Your Plan’s Progress

• Use your data wisely

• Learn from your mistakes and successes

• Don't accept mediocrity when it comes to patient care
Presenting Your Findings

• Tables
  – When the display will be used to look up individual values or the quantitative values must be precise
  – Data expressed in words or numbers
  – Data arranged in columns and rows

• Graphs
  – When the message you wish to communicate resides in the shape of the data (that is, in patterns, trends, and exceptions
  – Data expressed graphically as a picture
  – Data arranged in relation to one or more axes with scales that assign meaning to the values
Presenting Your Findings continued

• Before you decide how to present the data, think about what you want to say
• If you can communicate your message clearly, efficiently, and with the desired impact in a simple sentence, that's what you ought to do
• If your message requires the precision of a table of numbers and text labels to identify what they are, that's what you ought to use
• Different types of graphs are designed to communicate different types of messages
• Too often, data presentations try to impress rather than express—and entertain when they should explain
• The purpose of a graph is not to provide a means to interpret the precise value of each bar, line, or data point.
• Instead, the purpose is to see the shape of the data, and from that shape discern meaningful patterns, such as trends and exceptions.

From: Common Mistakes in Data Presentation. Stephen Few. Perceptual Edge
Pitfalls of Measurement

- Amassing too much data
- Focusing on the short term
- Failing to base decisions on the data
- Dumbing the data
- Measuring too little
- Collecting inconsistent, conflicting and unnecessary data
- Driving wrong performance
- Encouraging competition and discouraging teamwork
- Establishing unrealistic or unreasonable measures
- Failing to link measures
Sustaining

• Organizations trying to improve are under even more critical pressure to close the engagement gap
  – Remember the 4Es, engage is the first
• Report your metrics and measurement data
• Stakeholders must sustain the change
  – Process change also requires a change in heart, soul and behaviors of the people involved
• CHANGE SUCCESS: Depends on Stakeholder Adoption
Annual Program Evaluation

• Written from your *Infection Control & Prevention Progress Report*
  – Goals, objectives, strategies, progress with analysis and evaluation for the entire year in this one document.
  – Quickly cut and paste to create the annual program evaluation
• Then add next steps to address year’s results or Q4 results
• Add in the next steps in the new year’s risk assessment
Example- *C diff*

- **Q4 evaluation** - "*C diff* rate remains high, 13,10,000 pt days. ABT stewardship CME given. Chief of Medicine agreed to charter PIP addressing unnecessary ABT”

- **Annual report**  “Daily IP rounds with focus on contact precaution compliance conducted throughout the year, yielding opportunity to improve isolation cart stocking. Contact precaution compliance improved after PIP team implemented Env Services as the stocker. Glitch in lab module underscored importance of change control process to ensure any EMR build flows across other care modules. *C diff* rates remained high at 13/10,000 pt days. ABT Stewardship CME given and outcome is a PIP team charter to decrease unnecessary ABT. For coming year, *C diff* surveillance will continue and ABT usage will be trended."
Next Year’s Risk Assessment

• Assess for *C diff* again
• Assess for the possibility of expanding MDRO surveillance to include CRE, ESBL, MDR *Pseudomonas* etc.
• Assess for ABT stewardship asking the probability of unnecessary ABT orders
  – Depending on score and priorities, set a goal and launch the strategies to achieve it.
CMS Hospital QAPI Systems Related to Infection Prevention and Control

• 1. B.1 The Infection Control Officer(s) can provide evidence that problems identified in the infection control program are addressed in the hospital QAPI program (i.e., development and implementation of corrective interventions, and ongoing evaluation of interventions implemented for both success and sustainability).