

Cultivating Roots of Quality Improvement

Session 2: Heart of the Matter: Tools to Determine the Problem

May 4, 2022

Your Guides

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Improvement Advisor
Cynosure Health

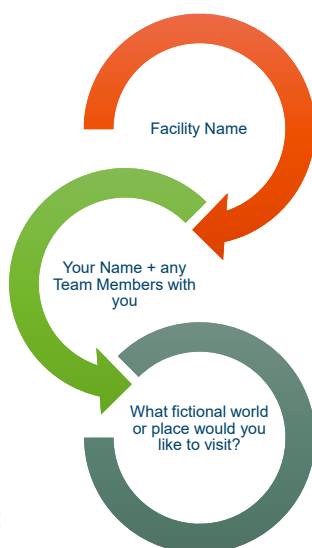
A rural Long Island, NY girl who grew up surrounded by corn and potato fields. Moved to San Francisco in the early days of the AIDS epidemic (1982) and has lived there ever since. Barb's joy is supporting infection prevention, patient safety and quality improvement in urban and rural settings especially in Montana.



Jennifer Wagner, CPHQ
Rural Hospital Improvement
Coordinator
MT Flex & HQIC Programs

A rural Montana girl from birth with fifteen years of learning from and building relationships with rural healthcare providers has instilled a drive and passion in Jen to help fill foundational needs in quality improvement concepts and integration.

Chat Box Roll Call



Bitterroot Health – Daly Hospital
Cabinet Peaks Medical Center
Central Montana Medical Center
Community Hospital Of Anaconda
Fallon Medical Complex
Frances Mahon Deaconess Hospital
Garfield County Health Center
Holy Rosary Health Care
Missouri River Medical Center
Pioneer Medical Center
Phillips County Hospital
St. Luke Community Hospital
Wheatland Memorial Healthcare

Reminders

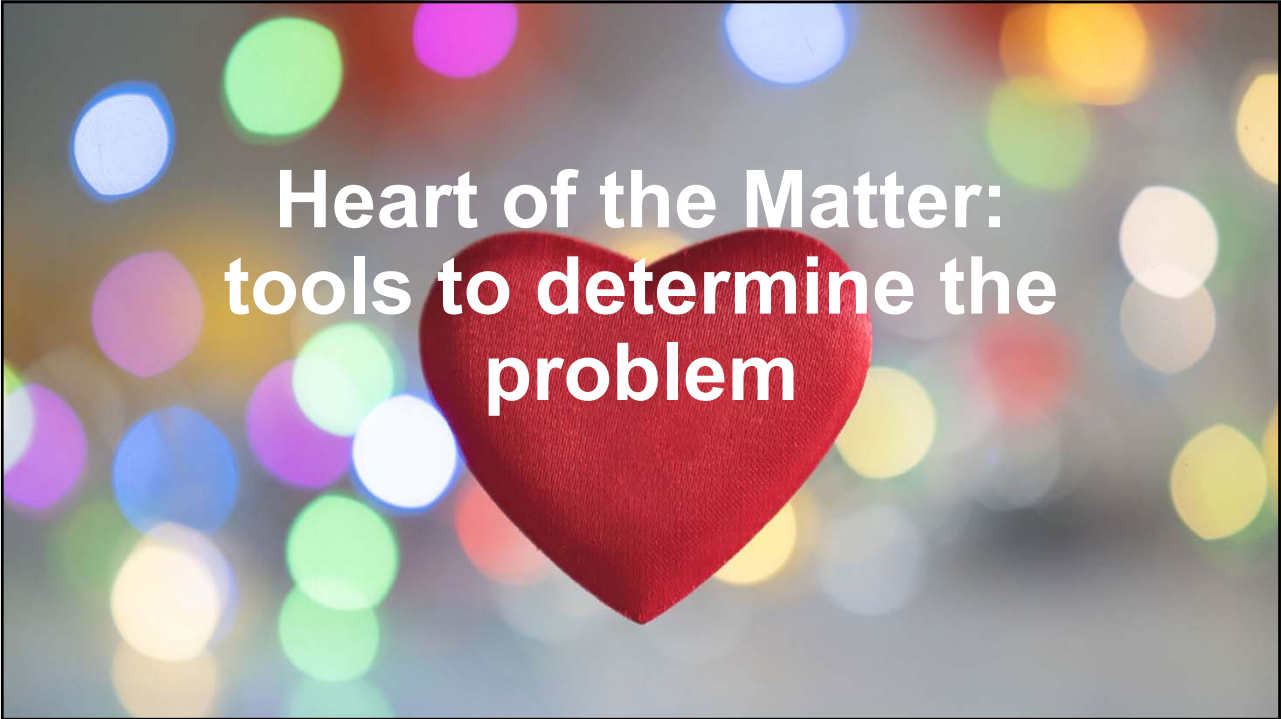
Project Expectations

- Attend live sessions or view the recording.
- Complete assigned Practical Applications that will help support your learning.
- Engage in and contribute to group discussions.

Education Session Expectations

- Please turn your camera on if you are able. Its really hard for facilitators and attendees to connect with black boxes.
- Speaking up is preferred over the chat for clarity and efficiency.
- Use the Raise Hand feature to speak up. We will watch and then 'call on' you.






**Heart of the Matter:
tools to determine the
problem**



**And...the solution(s)
to the problem**



Question for the group



How do you know when your processes are not resulting in optimal outcomes?



Sources of information?



Sources of information

Patient
Experience
(e.g., HCAHPS)
scores

Quality Boards:
Readmission
rates

Huddles: current
events e.g.,
CAUTI

Staff meetings

Hallway
conversation

Staff interviews

More sources

Patient and staff
interviews

Observations of practices
(e.g., hand hygiene)

The local news

How to discover
the reasons for
failure?



Channel your
curious child



I ran a red
light

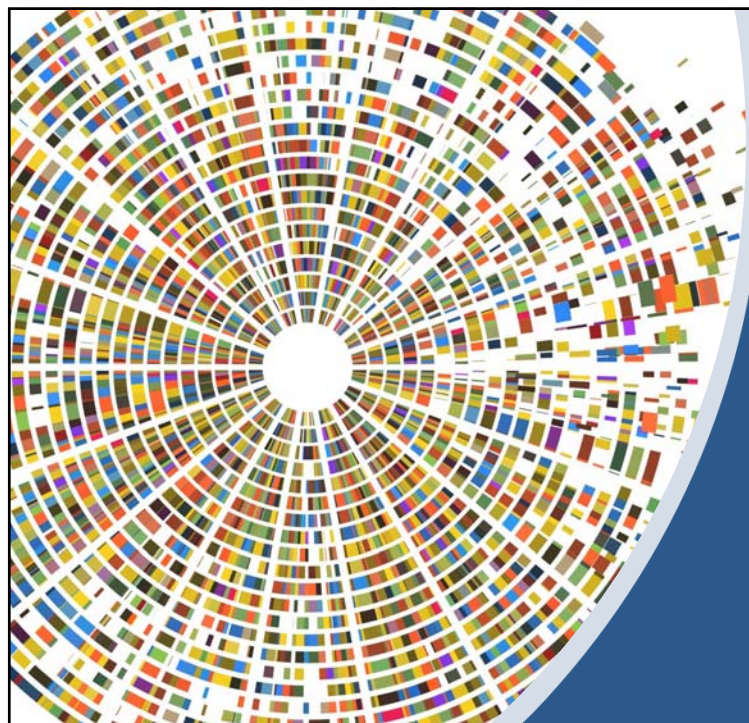
Why? I was late for work

Why? I woke up late

Why? Alarm didn't go off

Why? Phone didn't charge

Why? I forgot to plug it in



Let's role
play; focus
on a patient
readmission



Readmission interview

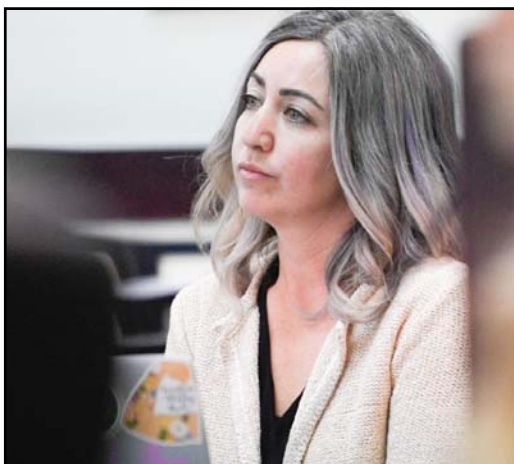
- Why are you back with us so soon?
- Why did you not fill your prescriptions?
- What other 'Why' questions would you ask?



Patient was given
wrong medication

Patient was
given a
medication that
resulted in
death

Why?



What's the problem and
how do we solve it?

Deep Dive Example

Deep Dive into C. difficile:
A tool to assess root causes of healthcare-onset C. difficile and the impact of culturing practices

Antibiotic and Laboratory Stewardship are primary drivers of healthcare-onset C. difficile. This tool is intended to guide analysis of culturing practices, antibiotic prescribing practices, risk factors and potential gaps.

Patient Name:	DOB:
Medical Record:	Date and time of admission: / /
From: <input type="checkbox"/> home <input type="checkbox"/> another hospital	SNF/LTAC/NH
Was patient discharged from our facility in the last 30 days? <input type="checkbox"/> Yes (date:) <input type="checkbox"/> No	
Any previous history of a positive C. difficile stool result? <input type="checkbox"/> Yes (date:) <input type="checkbox"/> No	
Our clinical lab uses the following test(s) to screen stool for C. difficile:	
<input type="checkbox"/> NAAT (stand-alone)	<input type="checkbox"/> GDH plus toxin
<input type="checkbox"/> NAAT plus toxin	<input type="checkbox"/> GDH plus toxin, arbitrated by NAAT
<input type="checkbox"/> other:	
Date and time CDI stool test was ordered:	
Where was patient at the time the CDI stool test was ordered?	<input type="checkbox"/> Emergency Department <input type="checkbox"/> In-patient unit:
Date and time CDI stool specimen was obtained:	
Where was patient at the time the specimen was obtained?	<input type="checkbox"/> Emergency Department <input type="checkbox"/> In-patient unit:
Did patient have 3 or more unexpected or unexplained liquid or unformed stools in the 24 hours prior to having the stool specimen collection?	<input type="checkbox"/> Yes <input type="checkbox"/> No*
*If 'No', criteria for testing not met. Investigate further to determine why specimen was ordered/submitted:	
Did the patient have any of these symptoms at the time the specimen was collected? (check all that apply)	<input type="checkbox"/> abdominal cramping <input type="checkbox"/> elevated WBC's <input type="checkbox"/> fever >100.4F/38F
Did the patient have any of these risk factors? (check all that apply)	
<input type="checkbox"/> Antibiotics in the last 2 months	
Name/Dose/Duration/Indication:	
Was indication for antibiotic necessity re-evaluated after 48 hours?	<input type="checkbox"/> yes <input type="checkbox"/> no
<input type="checkbox"/> Proton pump inhibitor (e.g. Protonix) daily for at least 3 days in the week prior to diagnosis?	<input type="checkbox"/> yes <input type="checkbox"/> no

HRET HIN CDI Root Cause Analysis Tool version 1 March 2018 1

CAUTI Discovery Tool – Specimen Collection Tracer

PROCESS	Chart #	Chart #	Chart #
(LAB ORDERS) There is:			
An order for a urinalysis and urine culture			
(SIGNS/SYMPTOMS) The patient has:			
At least one of the following: new onset or worsening of fever, rigors, altered mental status, malaise or lethargy with no other identified cause; flank pain, costovertebral angle tenderness; acute hematuria; pelvic discomfort			
A urinalysis that demonstrated at least one abnormality (e.g. + Nitrite, + Leukocyte esterase (LE), ≥5 WBC/hpf)			
(SPECIMEN COLLECTION and TRANSPORTATION) The following was observed:			
The urine specimen was collected from the sampling port			
The sampling port was scrubbed with a disinfectant (e.g. alcohol wipe)			
A dedicated transfer device designed to luer-fit directly onto the sampling port was used			
The current urinary catheter was removed, need for replacement was confirmed, and a new catheter was inserted before the urine specimen was collected			
The specimen is labeled correctly as clean catch or catheterized			
The urine specimen was either analyzed by the clinical lab within two hours of collection or was refrigerated (2-8°C) or in a tube containing a preservative.			
(LAB INTERPERETATION)			
Does the lab perform a culture only if UA is abnormal? (e.g. + Nitrite, + Leukocyte esterase (LE), ≥5 WBC/hpf)			
(TREATMENT)			
The urine sample was obtained from the urinary catheter BEFORE initiation of antibiotics			

Discovery Tool: themes?

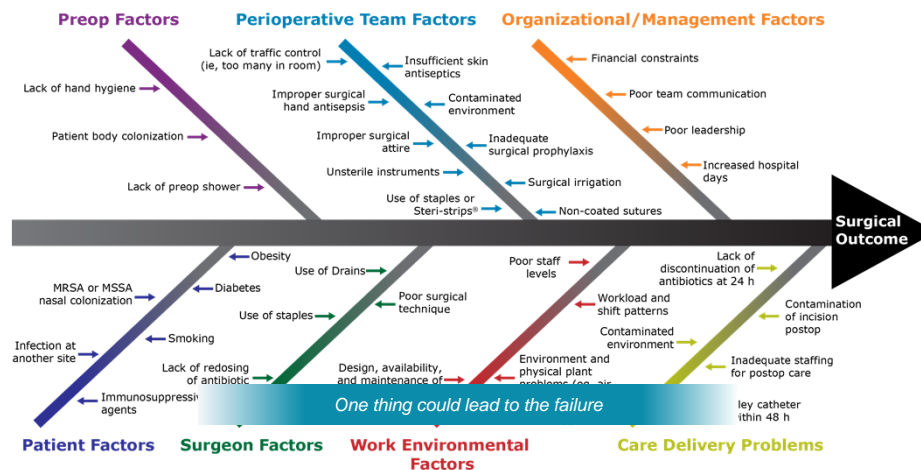
Mini RCA CDI Process Improvement Discovery Tool (Minimum 10 charts/Maximum 20 charts)

Note: Do NOT spend more than 20-30 minutes per chart!

Instructions: (1) Mark an X in the box where a process failure occurred. You may check more than one box per chart. (2) The processes with the most common failures could be a priority focus.

Process	Chart #	Chart #	Chart #	Chart #	Chart #	Chart #	Chart #	Chart #	Chart #	Chart #	Chart #	Chart #	Chart #	Chart #	Chart #	Chart #	Chart #	Chart #
Did the patient have less than 3 unexpected and unexplained stools in the 24 hrs. prior to Was the stool specimen submitted formed stool?																		
Did the patient receive a laxative or enema within 24 hours prior to stool?																		
Did the patient receive lactulose, tube feedings or IV contrast within 24 hours prior to stool?																		
Did the patient who occupied the room just before this patient have CDI?																		

Fishbone Example



Practical Applications – By 5/18

- ☐ Complete “3 Questions” tab in the Workbook.
- ☐ Schedule Scope Coaching with Barb.
- ☐ Complete Project Summary tab in the Workbook

THE 3 QUESTIONS		
These questions guide improvement work.		
QUESTION 1		
AIM/GOAL	What are we trying to accomplish?	
S Specific		
M Measurable		
A Achievable		
R Relevant		
T Time-bound		

PDSA																	
PROJECT SUMMARY																	
PROJECT START DATE:		PROJECT COMPLETION DATE															
PROJECT TITLE	Test																
PROJECT LEAD																	
TEAM MEMBERS																	
PLAN																	
This indicator or project supports ("X" all that apply):																	
<table border="1"> <thead> <tr> <th>Quality Assurance</th> <th>Quality Control</th> <th>Performance Improvement</th> </tr> </thead> <tbody> <tr> <td>High Risk</td> <td>Improved Health Outcome</td> <td>Transitions of care, including readmissions</td> </tr> <tr> <td>High volume</td> <td>Hospital Quality Objective</td> <td>Prevention/reduction of adverse events</td> </tr> <tr> <td>Problem Prone</td> <td></td> <td>Prevention/reduction of hosp. acquired condit</td> </tr> <tr> <td>Other</td> <td></td> <td>Prevention/reduction of medical errors</td> </tr> </tbody> </table>	Quality Assurance	Quality Control	Performance Improvement	High Risk	Improved Health Outcome	Transitions of care, including readmissions	High volume	Hospital Quality Objective	Prevention/reduction of adverse events	Problem Prone		Prevention/reduction of hosp. acquired condit	Other		Prevention/reduction of medical errors		
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BACKGROUND: Why is this important? What are the issues? What questions do you want to answer?																	



Schedule

Date	Topic	Practical Application (assigned)
April 20	Getting Started: The Model for Improvement & How to Choose a Change	Tool: 3 Questions
May 4	Heart of the Matter: Tools to Determine the Problem	Tool: Project Summary
May 18	What Tells the Story? How to Identify and Use Data	Tool: PDSA Cycle 1 and Summary
June 1	Just Do It...and Do It Again! Small Tests of Change and the Do-Study-Act of the PDSA Cycle	Tool: PDSA Cycle 2 +
June 29	The Leader Mindset	
July 13	No Blame No Shame: Addressing Patient Safety and Adverse Events	Poster development
July 27	Changing the Perspective Changes the Experience: Involving Patients and Family Advisors in Quality Improvement	
August 3	Celebration & Sharing	



Contact

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406-457-8000	415-823-7616 (cell)
Project Website	https://mtpin.org/qiroots/



Thank You For Your Time

*See you soon...and contact Barb if you have not
already done so!!*