

The Future Is Now: Designing Your Practice to Impact Patient Outcomes



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Disclosures

- ▲ Consultant-Michigan Hospital Association Keystone Center
- ▲ Consultant/Faculty for CUSP for MVP—AHRQ funded national study
- ▲ Subject matter expert CAUTI, CLABSI, HAPU, Sepsis, Safety culture
- ▲ Consultant and speaker bureau
 - △ Stryker's Sage business
 - △ LaJolla Pharmaceutical
 - △ Potrero Medical
- ▲ Baxter Advisory Board



Reboot/Reset



Life Coming Out of Crisis

Life is about how much you can take and keep fighting, how much you can suffer and keep moving forward.~ Anderson Silva

*Don't dwell on what went wrong. Instead, focus on what to do next. Spend your energies on moving forward toward finding the answer.
~Denis Waitley*

*If everyone is moving forward together, then success takes care of itself.
~Henry Ford*

One day? Or day one. You decide.





Self

Advocacy

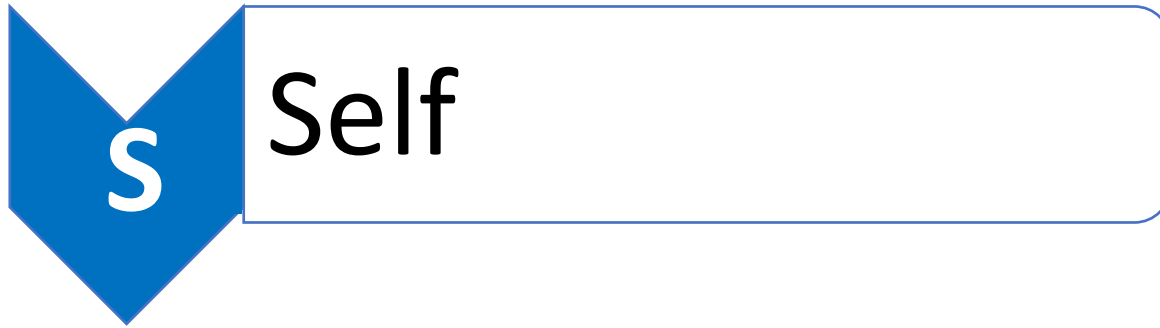
Fundamentals

Evidence

Team

Yes, I Will





Number 1 Respected Profession

Nursing

Gallup Poll: 82% Honesty &
Ethical Rating



So Why Don't We Feel Respected?



Reclaiming Professional Respect



Work Environment



Quality of Care You
Provide to Patient &
Families

What Behaviors or Communications Make You Feel
the Recipient of Respect?



Feeling of Respect or Not being Respected



Respected

- △ Feeling listened to
- △ Feeling revered for their knowledge
- △ Feeling trusted
- △ Feel part of the group
- △ Being acknowledged
- △ Sense of belonging/contributing
- △ Persons look out for each other and their support
- △ Fairness
- △ Free to speak
- △ Opportunities to excel

Not Being Respected

- △ Disregarded
- △ Not revered
- △ Not trusted
- △ Not supported
- △ Not recognized
- △ Closed conversation
- △ Speaking in a tone that is demeaning
- △ Ideas and opinions not considered a value priority
- △ Unsafe, guarded, pressured, put down



Respect



Self Respect



Self Respect



Internal Dialogue



External Dialogue



The Road to Respect

I spoke.

You listened.

I felt valued and honored.

You shared your opinion.

I trusted your wisdom.

The circle of respect was complete.

We saw in each other's eyes are common humanity.

Now, moving to a zone of mutual affirmation, we felt safe to trust and learn and nurture in the give-and-take of life.

Yasmin Morais 2006





Advocacy



Advocacy

- **Advocacy** is the pursuit of influencing outcomes — including policy and resource allocation decisions within systems & institutions — that directly affect people's current lives. (Cohen, 2001)
- Therefore, advocacy can be seen as a deliberate process of speaking out on issues of concern in order to exert some influence on behalf of ideas or persons.



Advocacy Starts with Us



Broaden the Definition of Advocacy

“It may seem a strange principle to enunciate as the very first requirement in a Hospital that it should do the sick no harm.”

Florence Nightingale

Advocacy = Safety



Patient Advocacy/Safety Related to Clinical Practice



- 🔗 Nurses knowledge of the Evidence based care
- 🔗 Ability to deliver the care to the right patient at the right time, every time it is needed
- 🔗 The ability to communicate patient concerns in a concise, data driven manner and take appropriate action
- 🔗 Understanding that I am the voice of the patient



Why Effective Communication May Be Challenging for Nursing



The Silent Treatment: April 2011



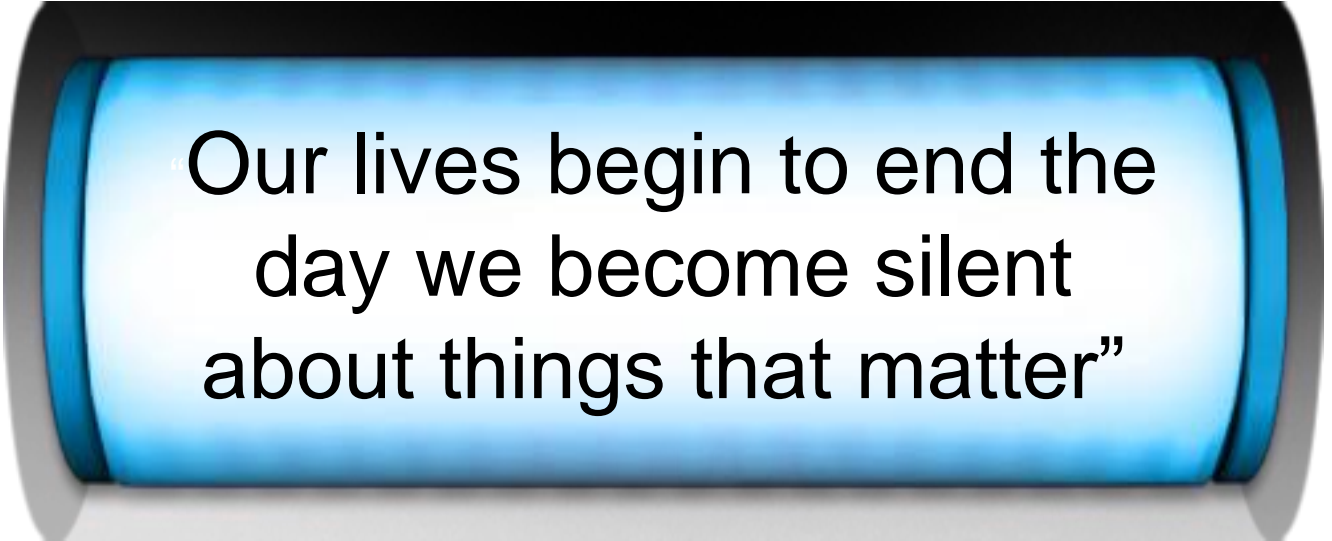

- 85% of workers reported a safety tool warned them of a problem that may have been otherwise missed & could harm a patient
- Safety tools include: handoff protocols, checklists, COPE, automated medication dispensing machines.
- 58% said they got the warning, but failed to effectively speak up & solve the problem
- 3 “undiscussable” issues: dangerous short cuts, incompetence & disrespect (4/5 nurses)
- 1/2 say shortcuts lead to near misses
- 1/3 say incompetence leads to near misses
- 1/2 say disrespect prevented them from getting others to listen or respect their opinion
- Only 16% confronted the disrespectful behavior




What Happens When You Speak Up!!

- 16% of healthcare workers who raise these crucial concerns observe better patient outcomes, work harder, are more satisfied and are more committed to staying in their jobs.

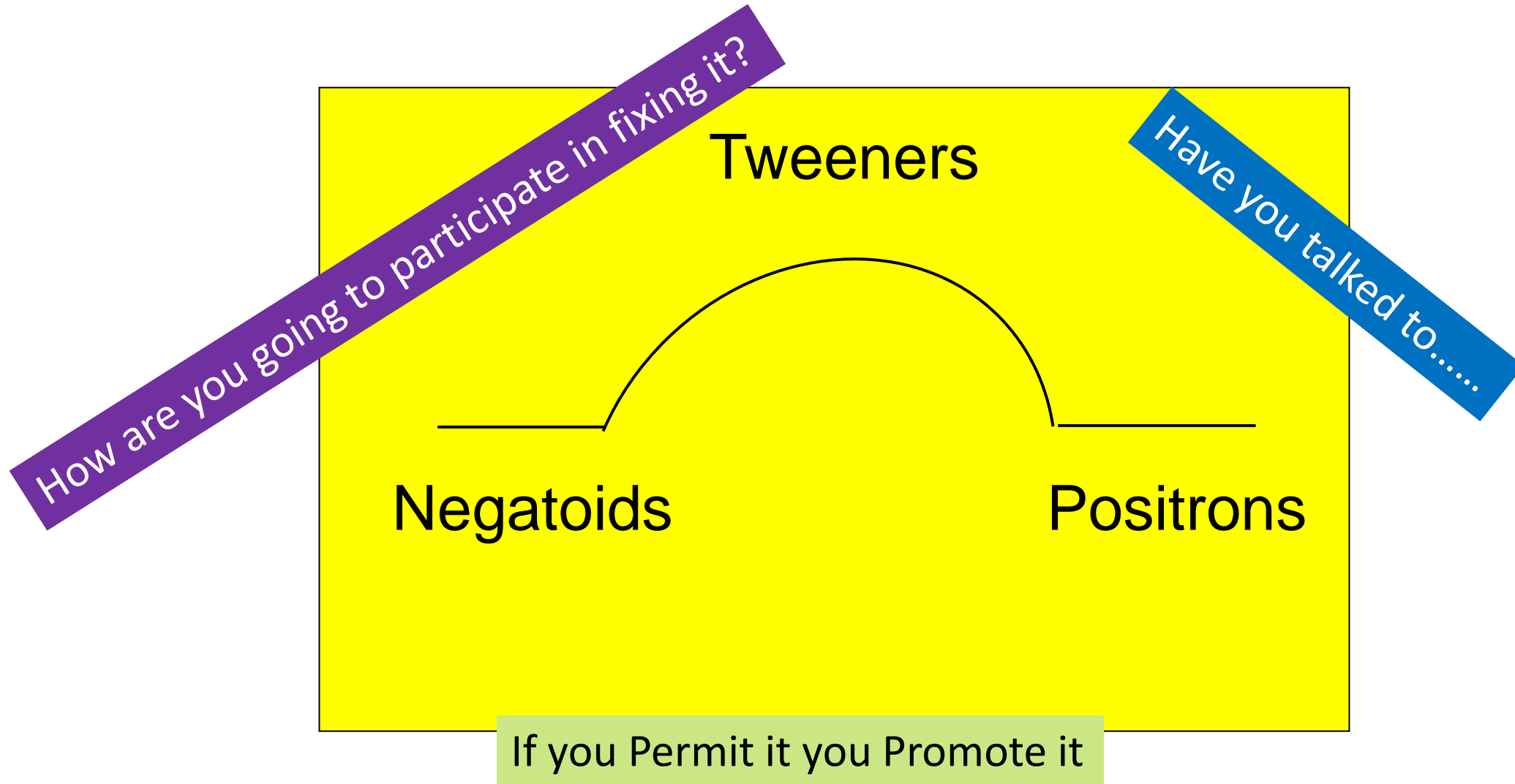





“Our lives begin to end the
day we become silent
about things that matter”



Understanding Your Culture & Communication Strategies



A blue scroll with a white border, tilted at an angle. The text is written in white, sans-serif font. The scroll has a rolled-up top and bottom edge.

A good word is an easy
obligation; but not to speak
ill requires only our silence;
which costs us nothing.

John Tillotson



Courage



“Courage is what it takes to stand up and speak. Courage is also what it takes to sit down and listen”

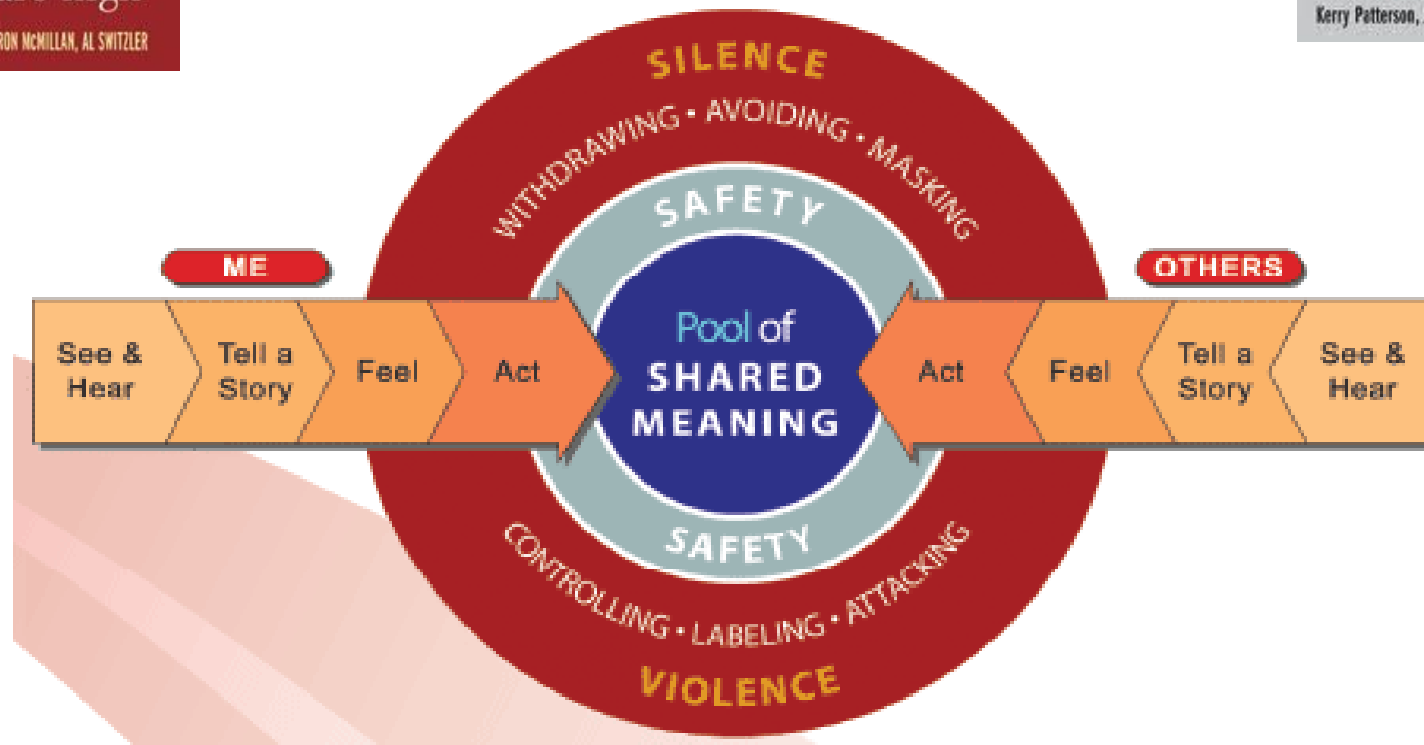
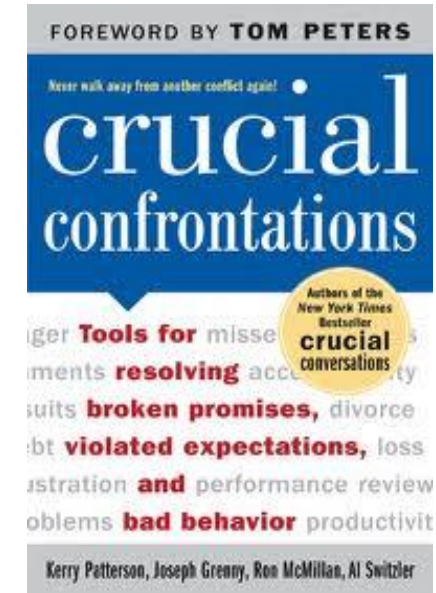
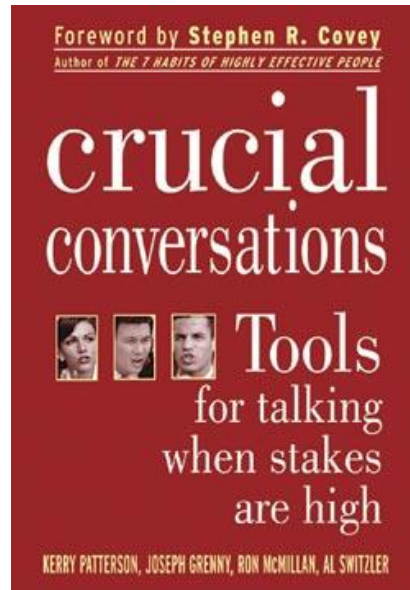
Winston Churchill

What to Do Individually?

- ⚙️ Prevent from occurring through training on effective communication
- ⚙️ Deal in real time to prevent staff or patient harm
- ⚙️ Initiate post event reviews, action and follow-up
- ⚙️ Make it as transparent as possible
- ⚙️ Zero-tolerance policy and procedure
- ⚙️ Intervention strategy: code white



Communication Training



Communication Strategies

Tools to help structure communication



- △ SBAR for communication with Doctors: **S**ituation, **B**ackground, **A**ssessment and **R**ecommendation
- △ CUS Words: I am **C**oncerned, I am **U**ncomfortable, This is not **S**afe

Use CUS words when assertion of your communication fails...things go wrong...concern expressed but mutual decision not reached or proposed action doesn't happen in time frame agreed upon

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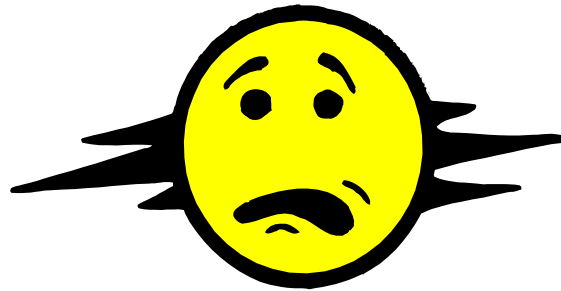




Fundamentals

Missed Nursing Care

- Any aspect of required patient care that is omitted (either in part or whole) or significantly delayed.
- A predictor of patient outcomes
- Measures the process of nursing care



**SORRY WE
MISSED YOU!**

Hospital Variation in Missed Nursing Care

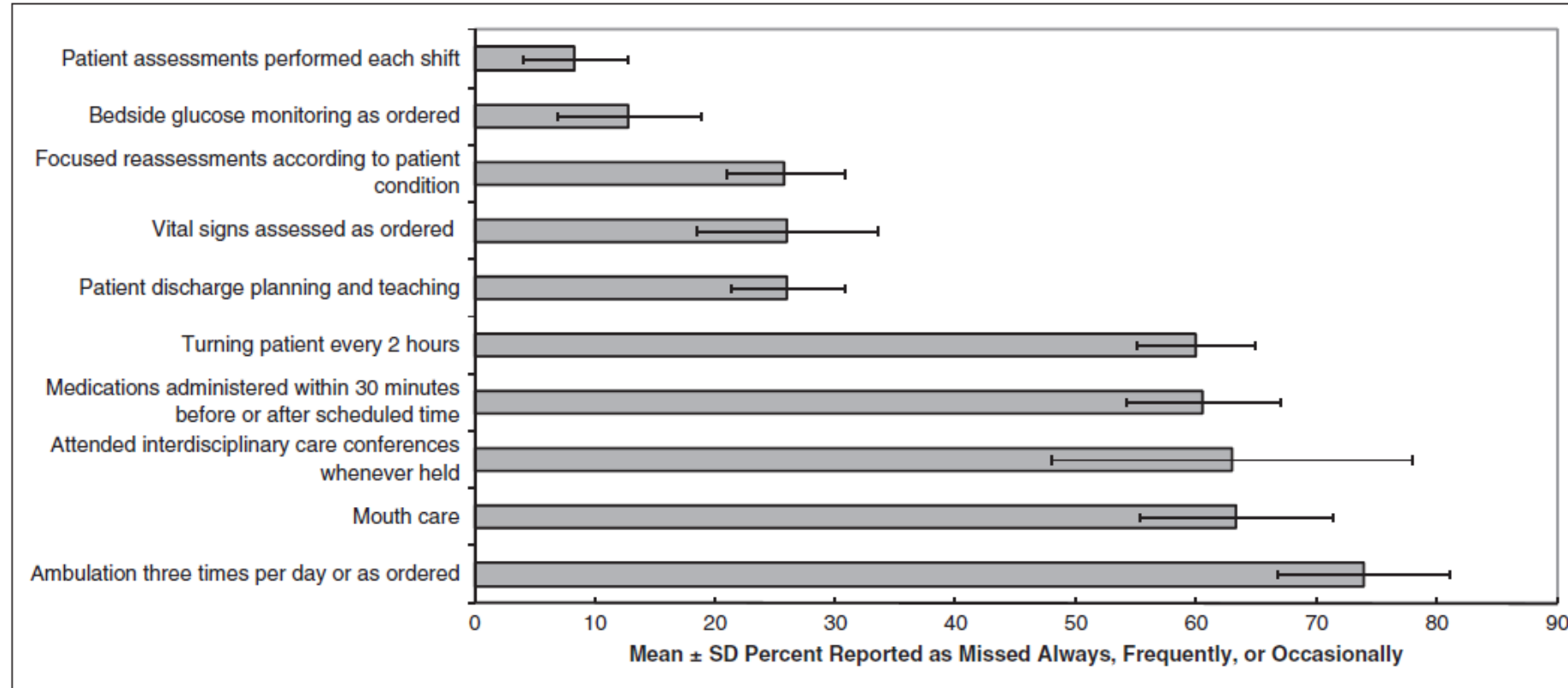


Figure 2. Elements of care most and least frequently missed. The solid bars represent the means across all 10 hospitals, and the range lines indicate the standard deviations.

Patient Perceptions of Missed Nursing Care

Table 2. Elements of Nursing Care by Ability of Patient to Report and Extent Missed*

	Fully Reportable	Partially Reportable	Not Reportable
			■ Patient assessment ■ Surveillance ■ IV site care
Frequently Missed	■ Mouth care ■ Listening ■ Being kept informed	■ Ambulation ■ Discharge planning ■ Patient education	
Sometimes Missed	■ Response to call lights ■ Response to alarms ■ Meal assistance ■ Pain medication and follow-up	■ Medication administration ■ Repositioning	
Rarely Missed	■ Bathing	■ Vital signs ■ Hand washing	

* IV, intravenous.

Rationing Care-How we Prioritize

Highest priority activities for nurses

△ Those which are likely to have an immediate negative impact

- Administering meds
- Medical directed treatments
- Procedures-wound dressings, labs

Lower priority activities for nurses

△ Those which show no immediate negative harm

- Ambulation
- Oral hygiene
- Emotional support
- Teaching



Rationing contributes to
functional and cognitive
decline

Protect The Patient From Bad Things
Happening on Your Watch



Implement
Interventional Patient Hygiene



Hand Hygiene

INTERVENTIONAL PATIENT HYGIENE

- ▲ Hygiene...the science and practice of the establishment and maintenance of health
- ▲ Interventional Patient Hygiene....nursing action plan directly focused on fortifying the patients host defense through proactive use of evidence-based hygiene care strategies

**Comprehensive
Oral Care Plan**

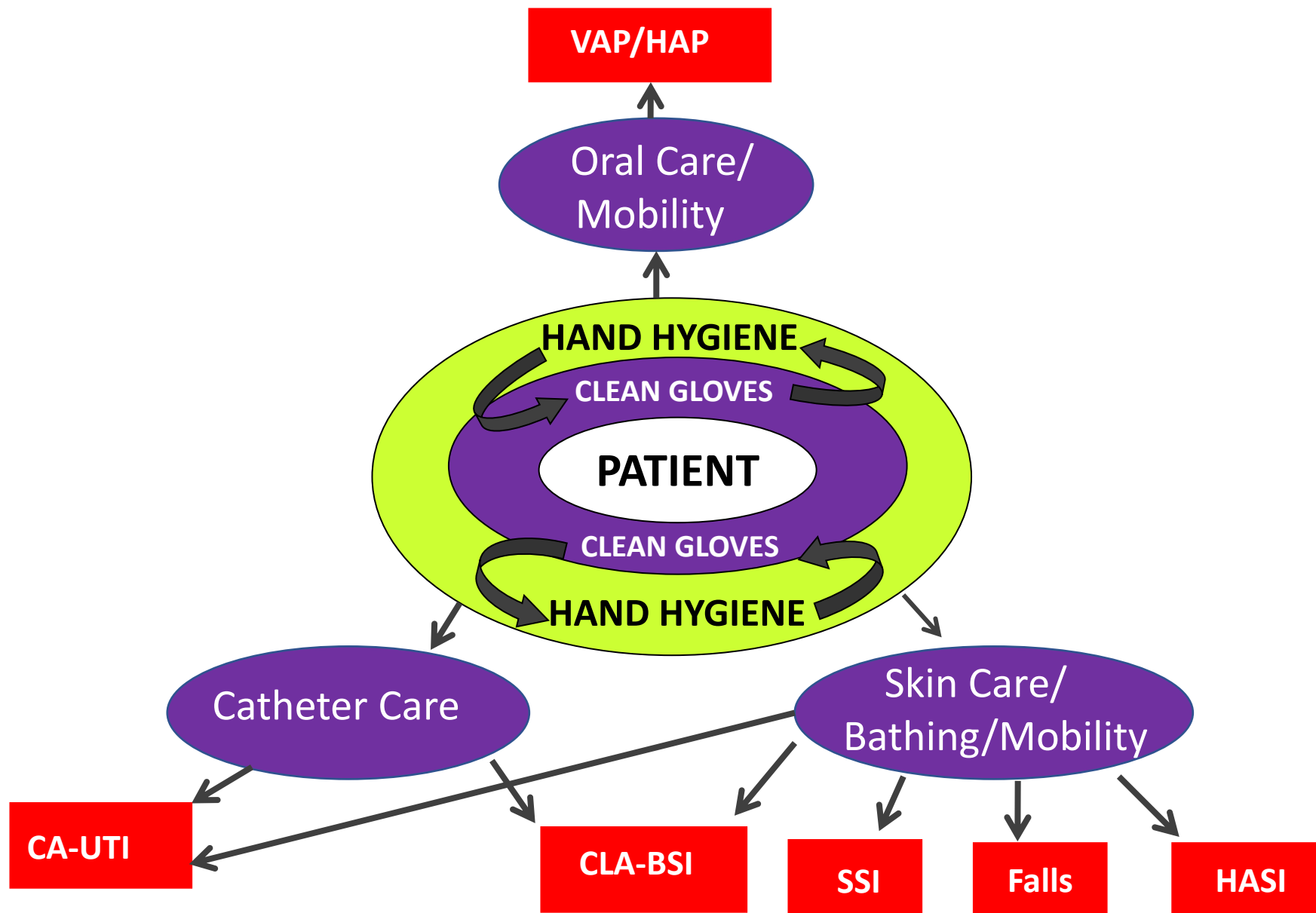
**Incontinence Associated
Dermatitis Prevention
Program**

**Pressure
Ulcer
Prevention**

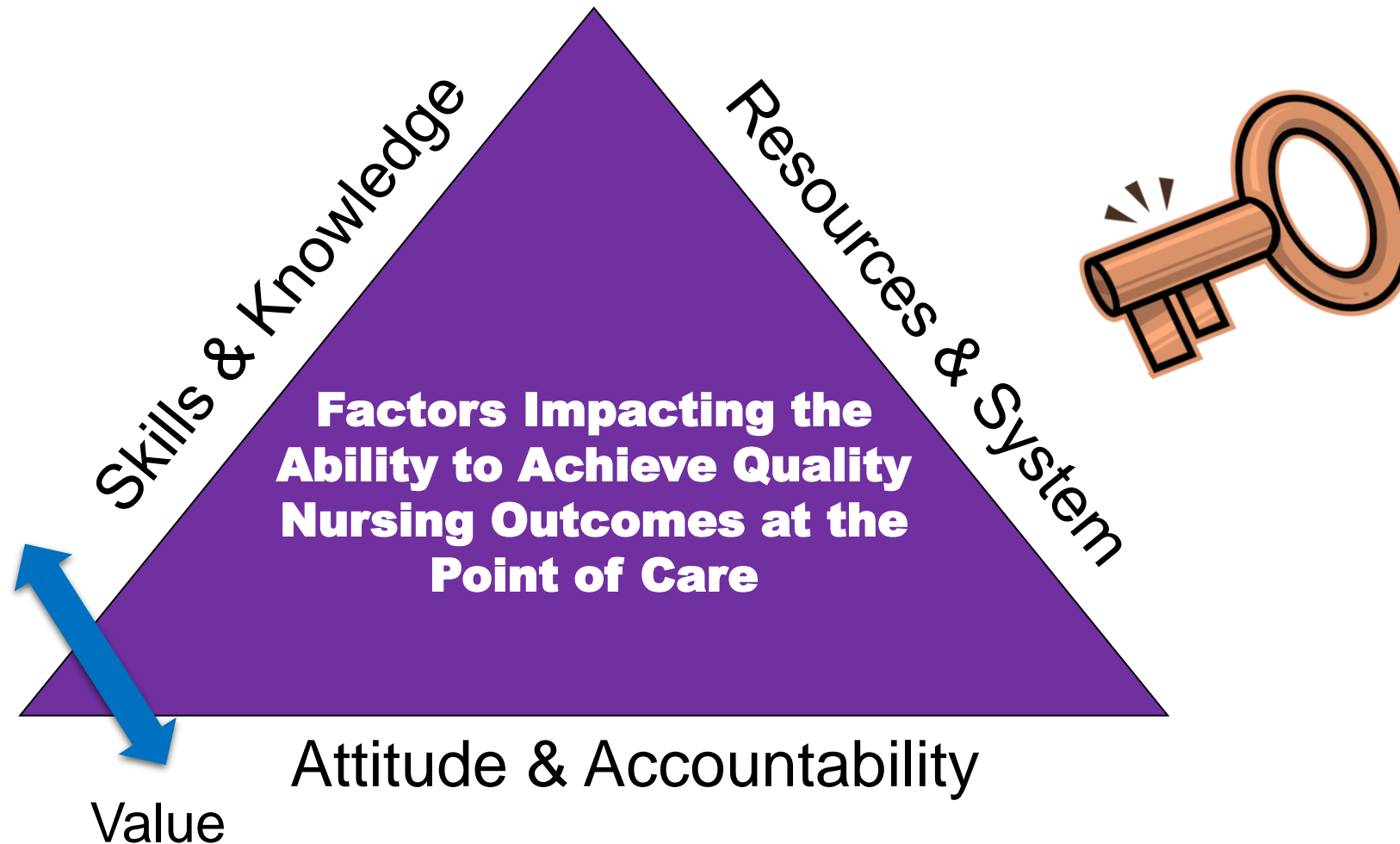
**Catheter
Care**

**Bathing &
Assessment**

INTERVENTIONAL PATIENT HYGIENE(IPH)



Achieving the Use of the Evidence



Preventing NV-HAP
Through Evidence Based
Fundamental Nursing Care



Why NV-HAP: Causes Harm



- 🔗 HAP 1st most common HAI in U.S.
- 🔗 1 in every 4 hospital infections are pneumonia
 - △ 60% non-ventilator
- 🔗 Increased mortality → 15.5%-30.9%
 - △ 8 ½ x more likely to die than equally sick patients who did not get non-vent HAP
- 🔗 Increased morbidity → 50% are not discharged home
 - △ Extended LOS → 7-9 days
 - △ Increased Cost → \$36K to \$54K per case
 - △ 2x likely for readmission <30 day
 - △ 46% ↑ ICU utilization
 - △ Increase antibiotic utilization

Magill SS, et al. NEJM 2018;379:1732-1744
Micek ST, et al. Chest. 2016 Nov;150(5):1008-1014.
Baker D, Quinn B et al. J Nurs Care Qual, 1-7.
Giuliano K, et al. Am J of Infect Control. 2018;46:322-327
Davis J et al. Pa Patient Safety Advisory, 2018;15(3)
Strassle PD, et al. Infect Control Hosp Epidemiol. 2020 Jan;41(1):73-79.
Lacerna CC, et al. Infec control & Hosp Epidemiology 2020;41, 547-552



Risk Factors for Pneumonia

Pathogens

- Hospital environment
- Healthcare workers
- Disruption of normal oral flora

Aspiration

- Supine position
- CNS depressant medications
- Invasive tubes

Weak Host

- Surgery
- Immobility
- Co-morbid conditions

HAP

Where does Pneumonia Start: Oral Bacteria during Hospitalization & Illness

🔬 Oral cavity

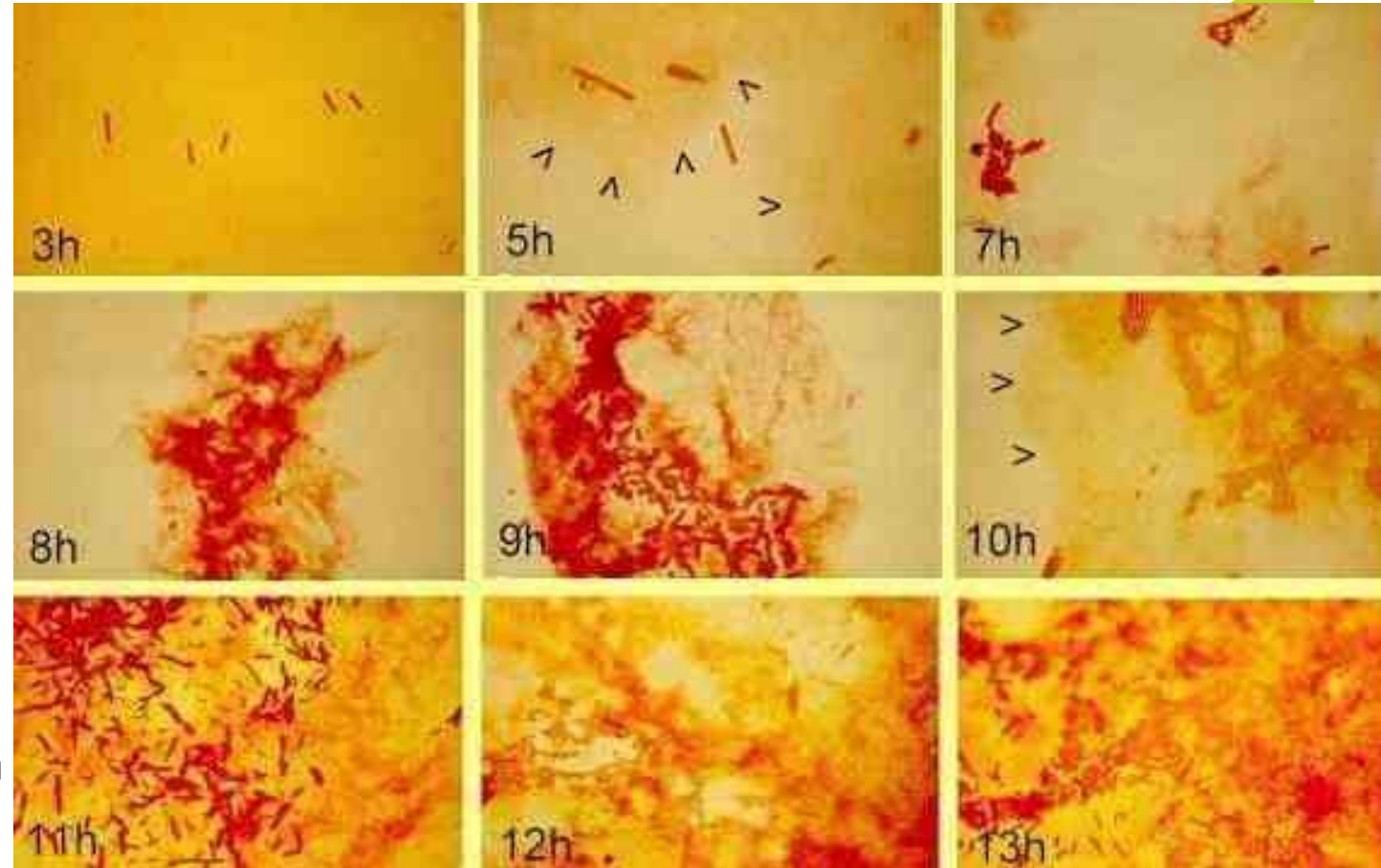
- △ > 1 billion oral microbes
- △ 700-1000 species
- △ Replicate's 5 x in 24hr period

🔬 Disruption of Microbiome

- △ Plaque, gingivitis, tooth decay
- △ Reduced salivary flow/change in pH

🔬 24-48 hours for HAP pathogens in mouth

🔬 If aspirated =100,000,000 bacteria/ml saliva into lungs



Oral Cavity & VAP



- 89 critically ill patients
- Examined microbial colonization of the oropharynx through out ICU stay
- Used pulse field gel electrophoresis to compare chromosomal DNA
- Results:
 - △ Diagnosed 31 VAPs
 - △ 28 of 31 VAPs the causative organism was identical via DNA analysis

- 49 elderly nursing home residents admitted to the hospital
- Examined baseline dental plaque scores & microorganism within dental plaque
- Used pulse field gel electrophoresis to compare chromosomal DNA
- Results
 - △ 14/49 adults developed pneumonia
 - △ 10 of 14 pneumonias, the causative organism was identical via DNA analysis



NV-HAP SMCS Research Findings: 2010

Incidence:

- ▲ 115 adults
- ▲ 62% non-ICU
- ▲ 50% surgical
- ▲ Average age 66
- ▲ Common comorbidities:
 - CAD, COPD, DM, GERD
- ▲ Common Risk Factors:
 - Dependent for ADLs (80%)
 - CNS depressant meds (79%)

24,482 patients and 94,247 pt days

Cost:

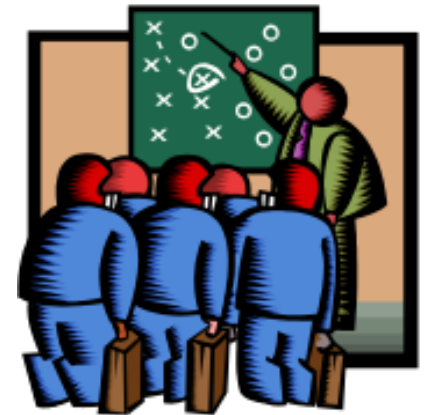
- ▲ \$4.6 million
- ▲ 23 deaths
- ▲ Mean Extended LOS 9 days
- ▲ 1,035 extra days



SMCS HAP Prevention Plan

Phase 1: Oral Care

- Formation of new quality team: Hospital-Acquired Pneumonia Prevention Initiative (HAPPI)
- New oral care protocol to include non-ventilated patients
- New oral care products and equipment for all patients
- Staff education and in-services on products
- Ongoing monitoring and measurement
 - Monthly audits

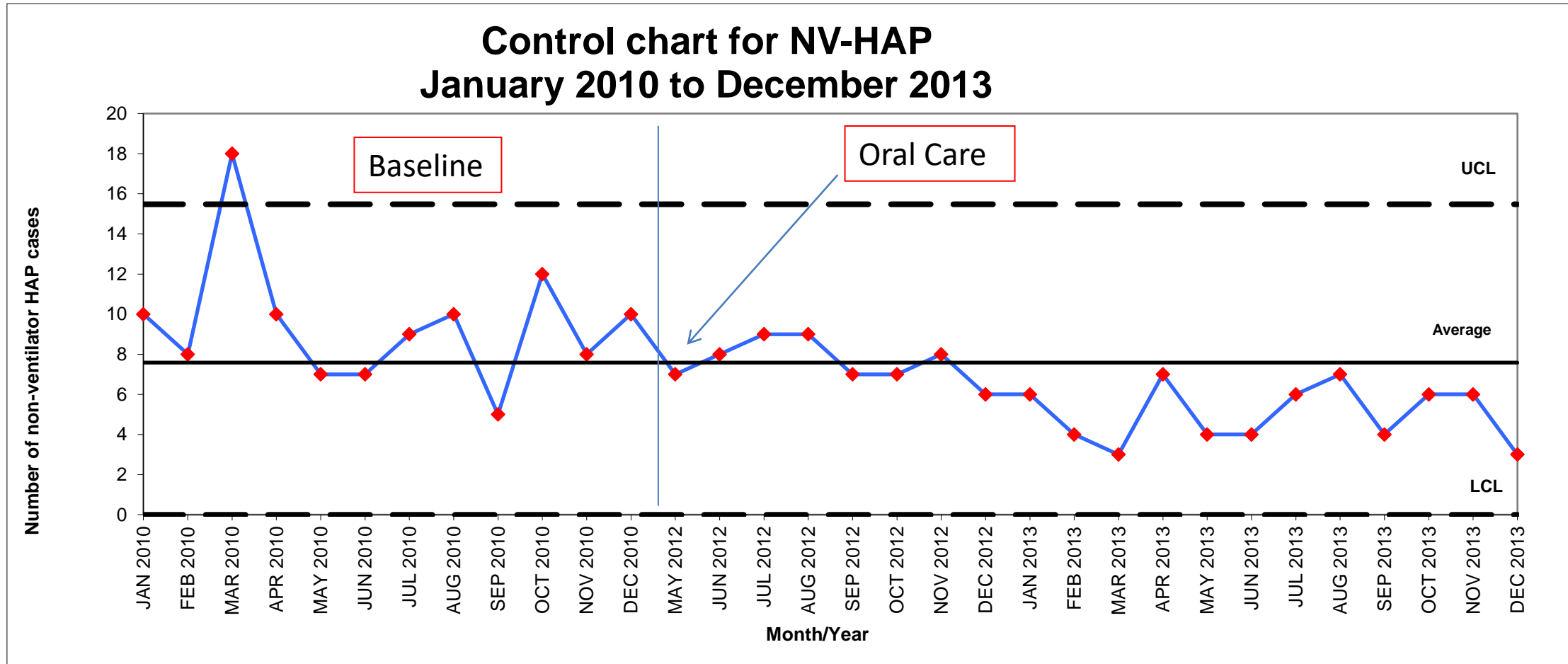


Protocol – Plain & Simple

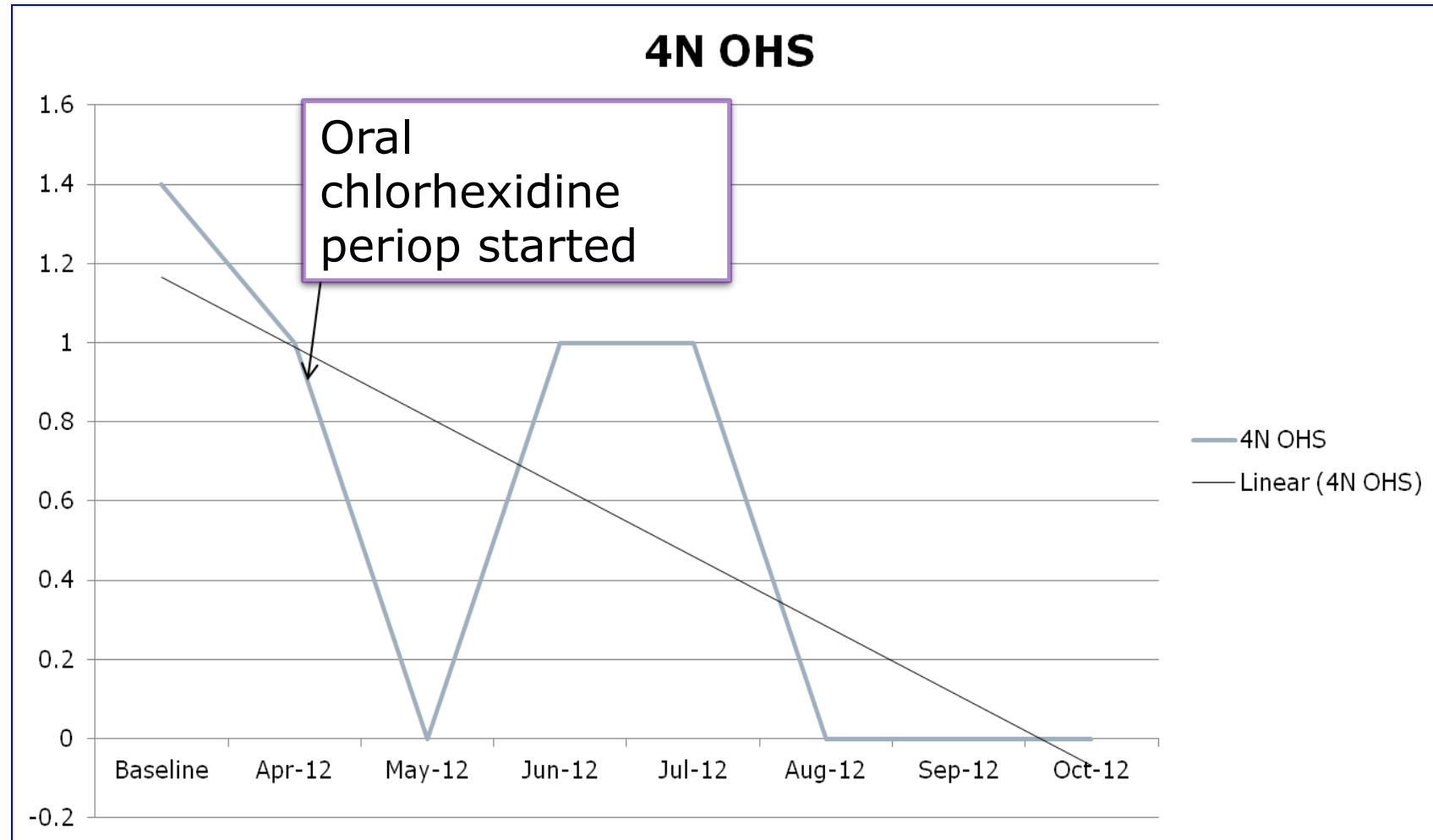
Patient Type	Tools	Procedure	Frequency
Self Care / Assist	Brush, paste, rinse, moisturizer <ul style="list-style-type: none"> • Soft-bristled toothbrush • Toothpaste with dentifrice • Antiseptic mouth rinse (alcohol-free) • Moisturizer (Petroleum-free) 	Provide tools Brush 1-2 minutes Rinse	4X / day
Dependent / Aspiration Risk	Suction toothbrush kit (4)	Package instructions	4X / day
Dependent / Vent	ICU Suction toothbrush kit (6) <ul style="list-style-type: none"> • CHG for vent & cardiac surgery patients 	Package instructions	6X / day
Dentures	Denture cup, brush Cleanser Adhesive	Remove dentures & soak Brush gums, mouth Rinse	4X / day

NV-HAP Incidence

50 % Decrease from Baseline



Open Heart Surgery Patients: NV-HAP Reduced 75%



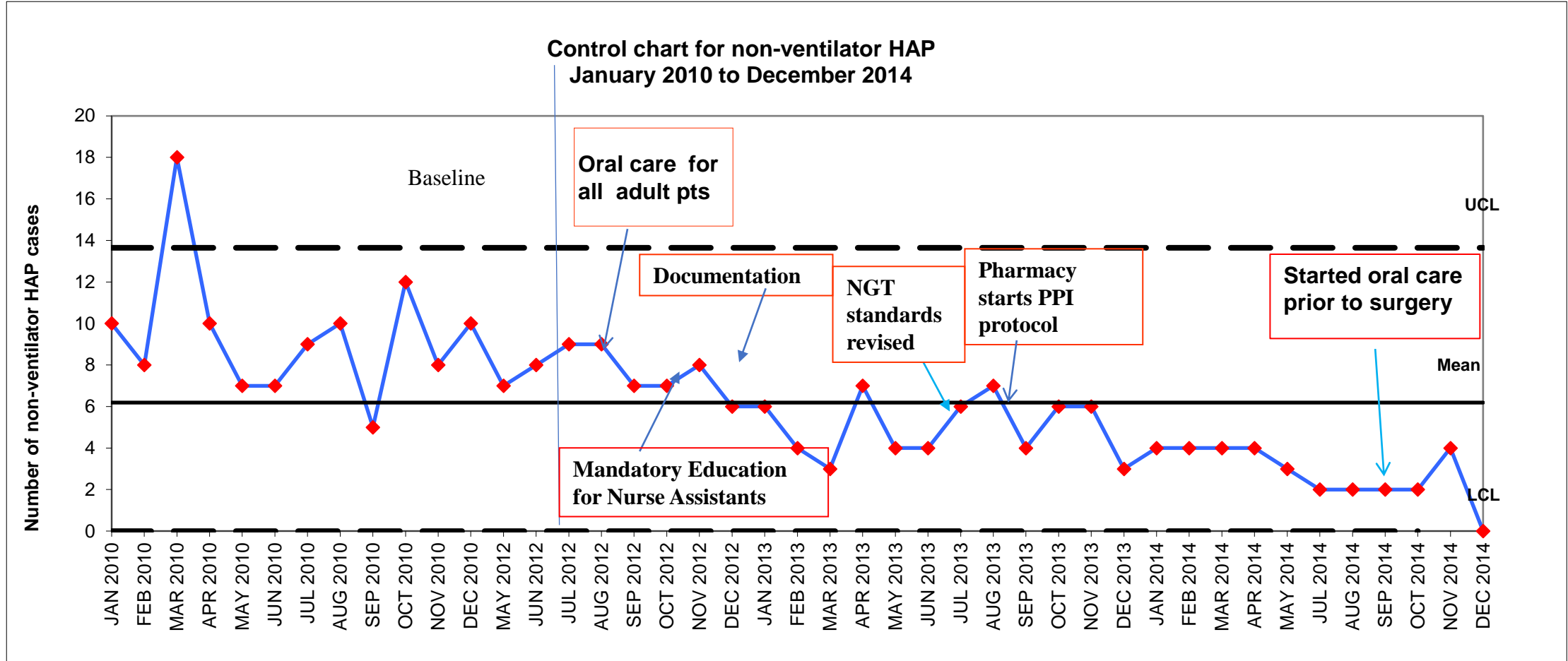
Return on Investment

- 60 NV-HAP avoided Jan 1 – Dec. 31 2013
- \$2,400,000 cost avoided
- 117,600 cost increase for supplies
- \$2,282,400 return on investment

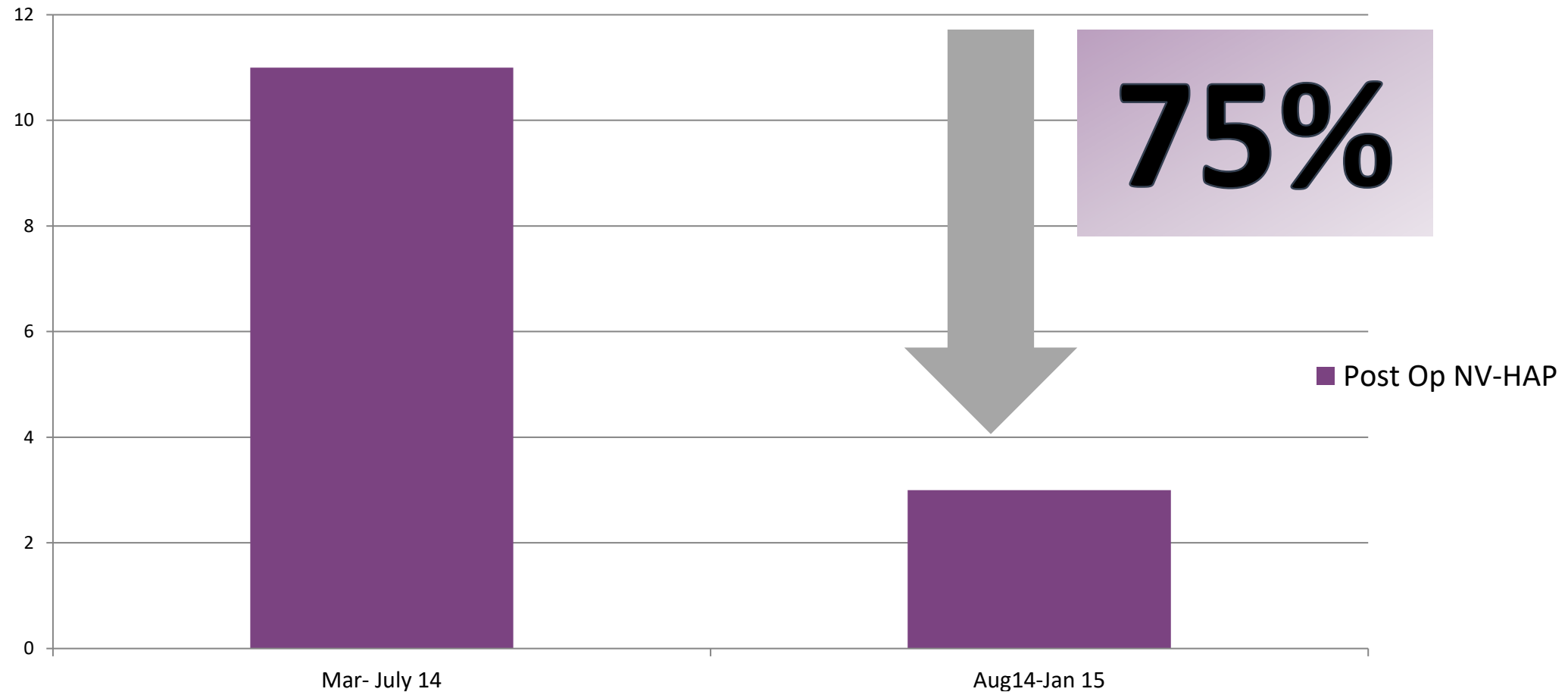
8 lives saved

PRICELESS

NV-HAP ↓ 70% from baseline!

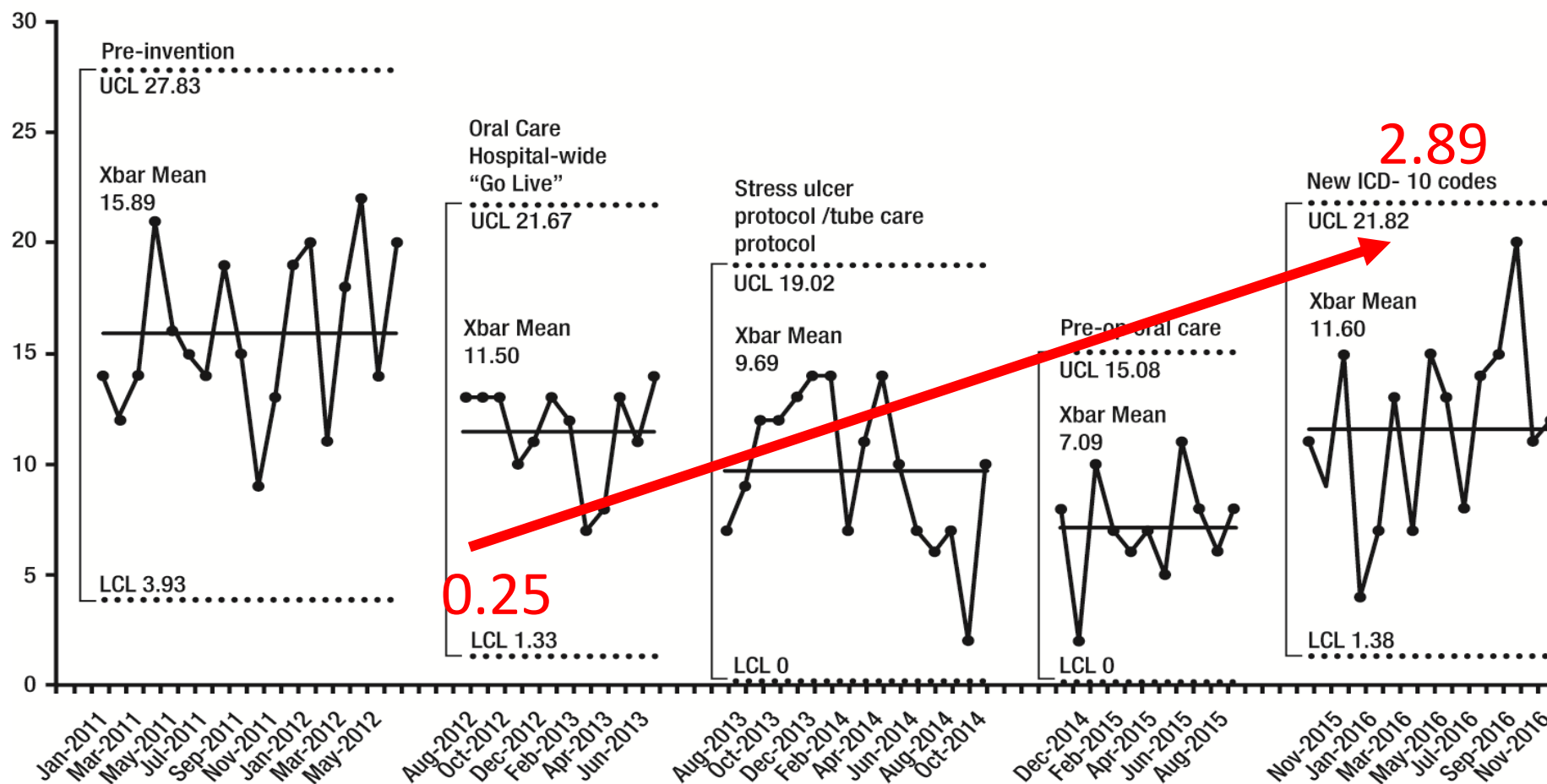


Post-Operative NV-HAP (all adult inpatient surgery) Incidence 6 months Pre-Oral Care vs. 6 Months After



Sustainability Hospital Wide Oral Care from .25 to 2.89 (almost 3x a day)

Figure 1: Statistical process control R and X-bar-charts:
International Statistical Classification of Diseases and Related Health Problems (ICD) codes (3 standard deviations)



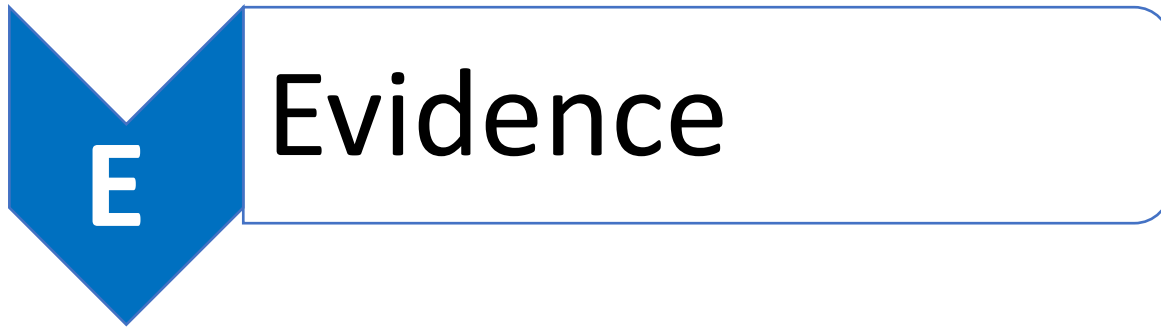
A photograph of a person with a backpack standing on a rocky ledge, looking out at a massive, snow-capped mountain peak under a clear blue sky. The person is in silhouette, and the mountain is partially covered in snow and ice.

WHEN WOULD NOW BE A GOOD TIME TO DO THIS?

**It is not enough to do your best; you
must know what to do, and THEN
do your best.**

~ W. Edwards Deming





Evidence



What is Good About EBP!!!

- 🔗 Firm foundation to do the right thing
- 🔗 Improved patient outcomes
- 🔗 Basis for interventions
- 🔗 Basis for evaluation
- 🔗 Ability to talk in a similar language with other disciplines
- 🔗 Methods allow correct and more expedient movement of evidence into practice



**Activity without purpose is
the drain of your resources**



We Make a Difference in Quality & Safety

- ▲ Increase nurse staffing was associated with; lower hospital related mortality, lower cardiac arrest, lower hospital acquired pneumonia in the surgical population, lower episodes of failure to rescue, lower UTIs, lower G.I. bleed/shock, lower falls & rates in hospital acquired pressure ulcers
- ▲ The risk of hospital deaths would increase by 31% or roughly 20,000 avoidable deaths each year if all hospitals had 8 patients per nurse instead of 4 (JAMA 2002)
- ▲ When nurses case managed children with asthma there were fewer absences from school
- ▲ 11% improvement in failure to rescue (HealthGrades 2009 Report)

We Make a Difference in Quality & Safety



- 🔗 Home care/discharge planning/APRN's; lower length of stay, lower healthcare costs, fewer hysterectomies
- 🔗 Patients in CCU with better nurse work environment experienced a 11% lower odds of 30-day mortality (Kelly DM Crit Care Med 2014)
- 🔗 Patient satisfaction directly correlated to registered nurse satisfaction (HCAHPS)
- 🔗 10% ↑ in the # of RNs ↓ lung collapsed by 1.5%, pressure ulcers 2%, Falls 3%, UTI < 1% (Urich Med Care 2003, 41(1):142-152)
- 🔗 Nurse's effect explained 7.9% of variance in patients' clinical condition during their hospital stay (Yakusheva O, et al, HSR, 2014)



Patient Safety Strategies Strongly Encouraged for Adoption with Moderate to High Evidence



- ▲ Preoperative and anesthesia checklists to prevent perioperative events
- ▲ Bundles with a checklist to prevent CLA-BSI
- ▲ Interventions to reduce use of urinary catheters; stop orders, reminders or removal protocols
- ▲ Bundle to prevent ventilator associated pneumonia
- ▲ Hand hygiene
- ▲ Multiple component initiative to prevent pressure ulcers
- ▲ Prophylaxis intervention for venous thromboembolism
- ▲ Using real-time ultrasonography for placement of central catheters



Patient Safety Strategies Encouraged for Adoption with Moderate to High Evidence



- 🔗 Interventions to reduce patient falls
- 🔗 Using clinical pharmacist to reduce adverse drug events
- 🔗 Documenting patient preference for life-sustaining treatment
- 🔗 Obtaining informed consent prior to medical procedures
- 🔗 Team training
- 🔗 Medication reconciliation
- 🔗 Using surgical outcome report cards
- 🔗 Rapid response systems
- 🔗 Computerized provider order entry
- 🔗 Using simulation training and patient safety efforts





Team



**There is no “I” in
TEAM...but there
is a “ME”**



Path to High Performing Teams



- Team Leadership
- Mutual performance monitoring
- Backup behavior
- Adaptability
- Team orientation

- The leader directs & coordinates team activities
- Team members monitor each other performance
- Team members anticipate & respond to one another's needs
- Team adjust strategies based on new information
- Prioritize team goals over individual goals

Shared Mental Model

Mutual Trust

Closed Looped Communication

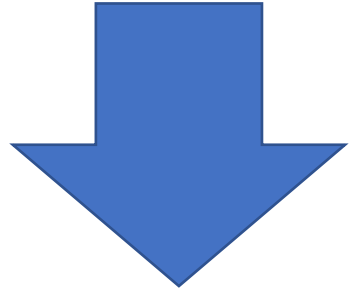


Tools and Strategies to Improve Communication and Teamwork

- ▲ Structured Handoff
- ▲ Huddles
- ▲ Daily rounds/goals
- ▲ Pre-procedure briefing
- ▲ Checklists



Hospitals With High Teamwork Ratings



- 🔗 Higher patient satisfaction
- 🔗 Higher nurse retention rates
- 🔗 Lower hospital costs



Tools Don't Create
Safety



People Do!!!



**The Most Powerful Force of Human
Behavior is Social Influence**





*“Setting an Example is
Not the Main Means
of Influencing
Others....It is the Only
Means”*

Albert Einstein



Yes, I Will



Yes, I Will

Focus on Achieving Nurse Sensitive Outcomes &
Commit to a Culture of Safety & Accountability



Yes, I Will

Be the Power of One

“ I am only one, but still I am one.

I cannot do everything, but still I can do something.

I will not refuse to do the something I can do.”

Helen Keller



Yes, I Will

“You gain strength, courage and confidence by every experience in which you really stop to look fear in the face. You must do the thing which you think you cannot do.”

Eleanor Roosevelt



Yes, I Will

Change and growth take place when a
person has risked himself & dares to
become involved with experimenting
with his own life

Herbert Otto



Yes I Will



Leap and the Net will Appear



Kathleen Vollman

ADVANCING NURSING THROUGH KNOWLEDGE & INNOVATION



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