Patient Safety, Accountability, and the Power of Possibility….No Turning Back

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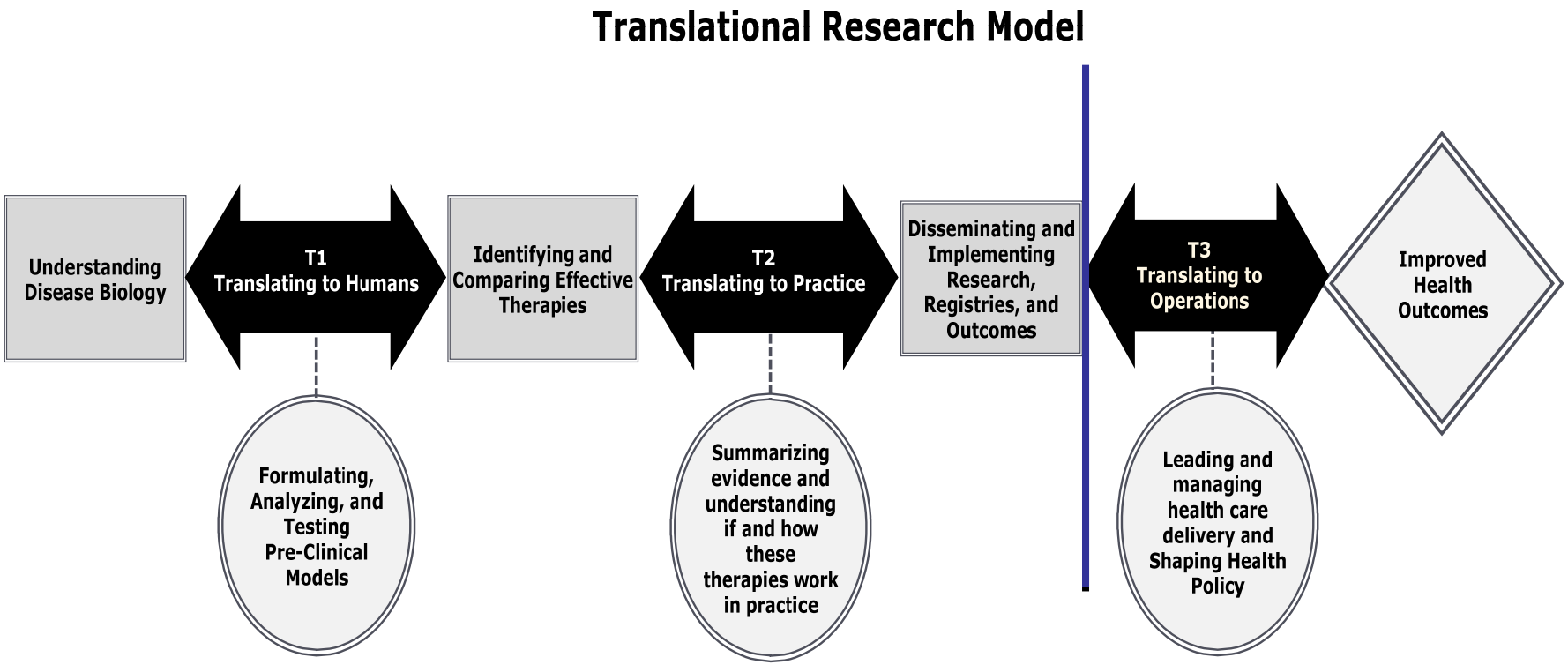
*Note: The former Johns Hopkins Quality and Safety Research Group QSRG)
Is now the research arm of
The Johns Hopkins Armstrong Institute for Patient Safety and Quality

Advance the Science of Healthcare Delivery



The Johns Hopkins Armstrong Institute* Model to Improve Care

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Translating Evidence Into Practice (TRiP)

1. Summarize the evidence in a checklist
2. Identify local barriers to implementation
3. Measure performance
4. Ensure all patients get the evidence
   - Engage
   - Educate
   - Execute
   - Evaluate

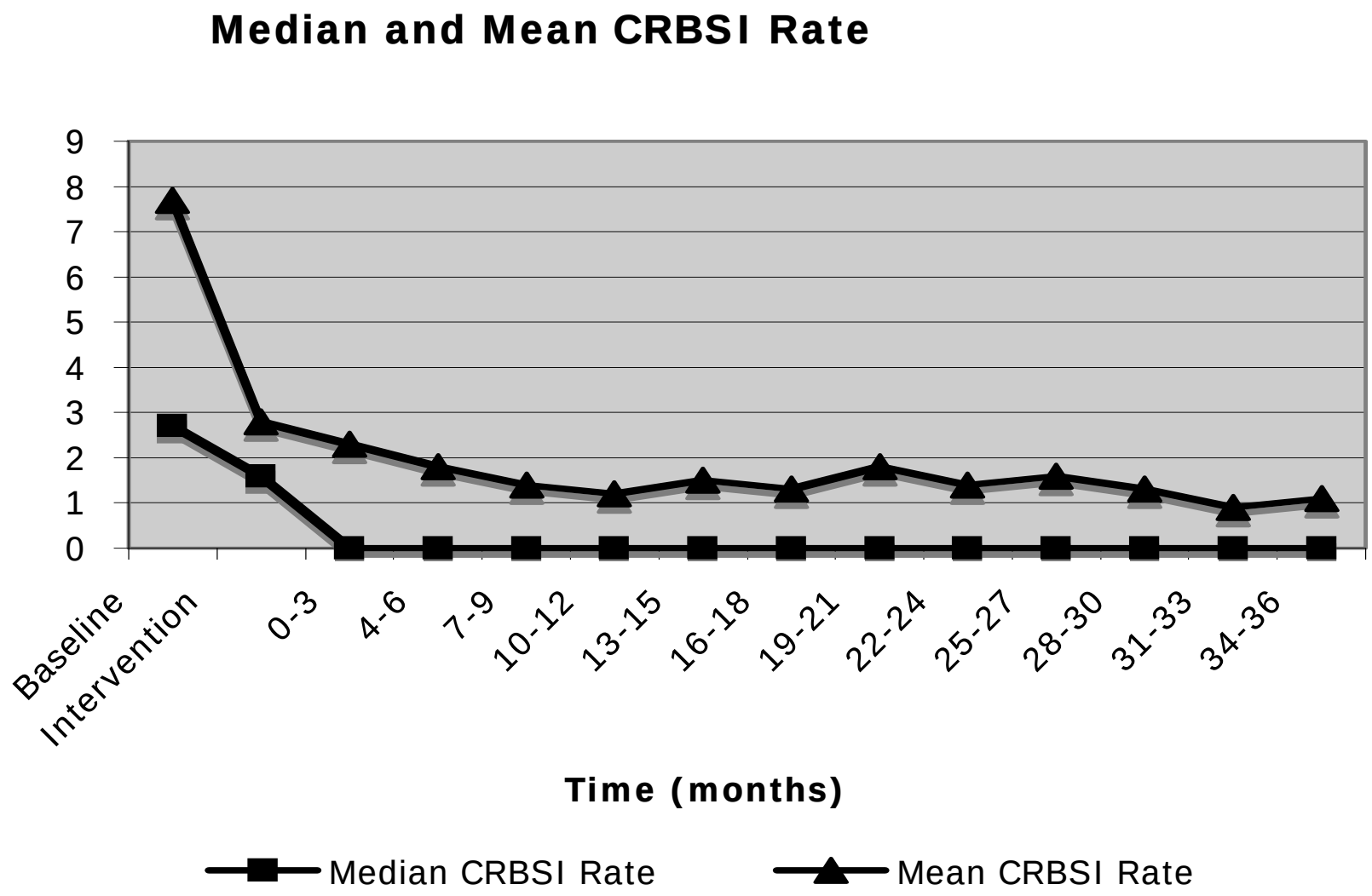
Central line associated Bloodstream Infections (CLABSI)

1. Wash your hands
2. Use chlorhexidin
3. Use full barrier precautions
4. Avoid the femoral site
5. Ask every day if lines can be removed

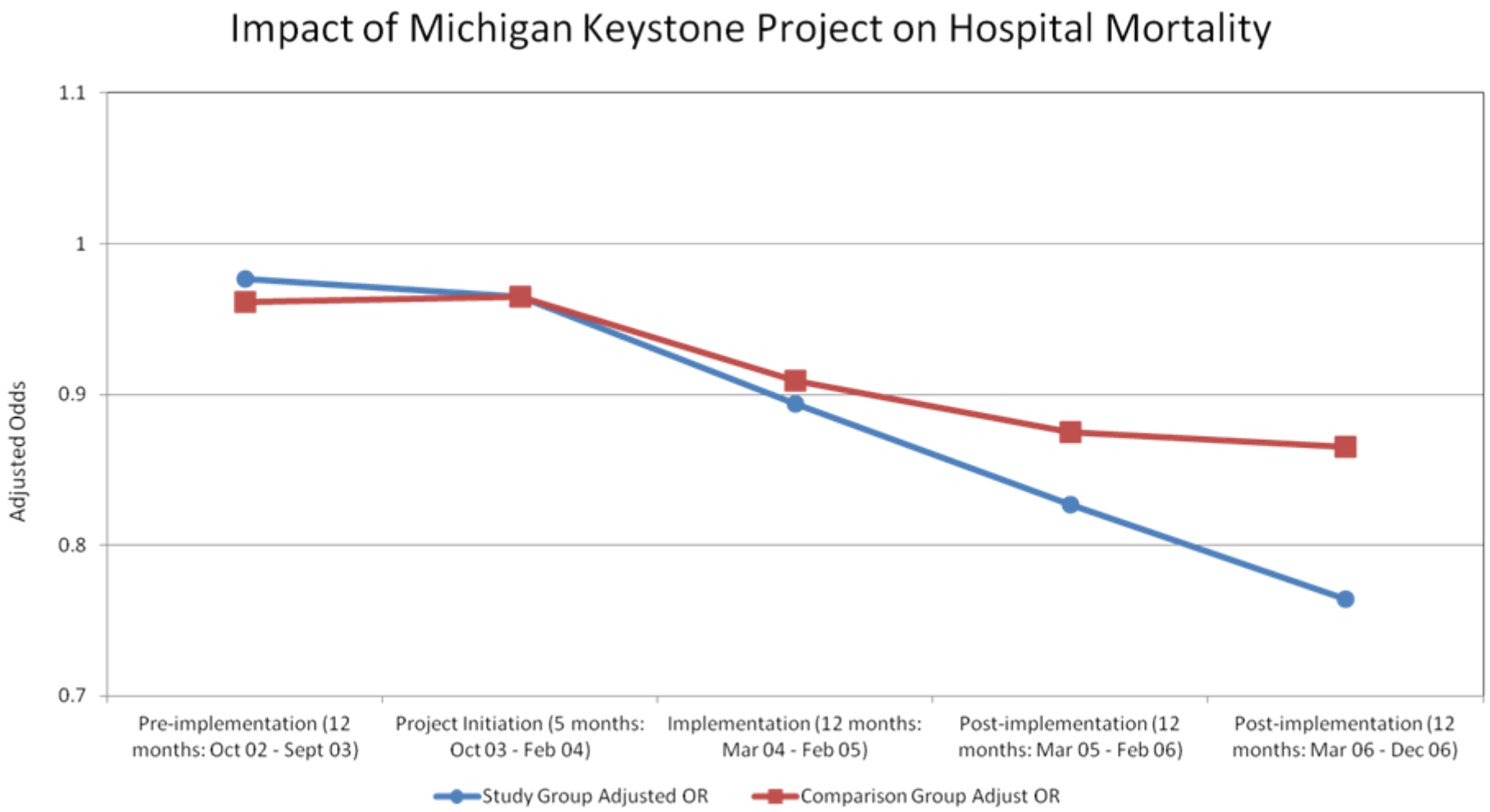
Comprehensive Unit based Safety Program (CUSP)

1. Educate staff on science of safety
2. Identify defects
3. Executive as member of unit based team
4. Learn from one defect per quarter
5. Implement teamwork tools (improve safety culture)

Michigan
CRBSI Rate Over Time



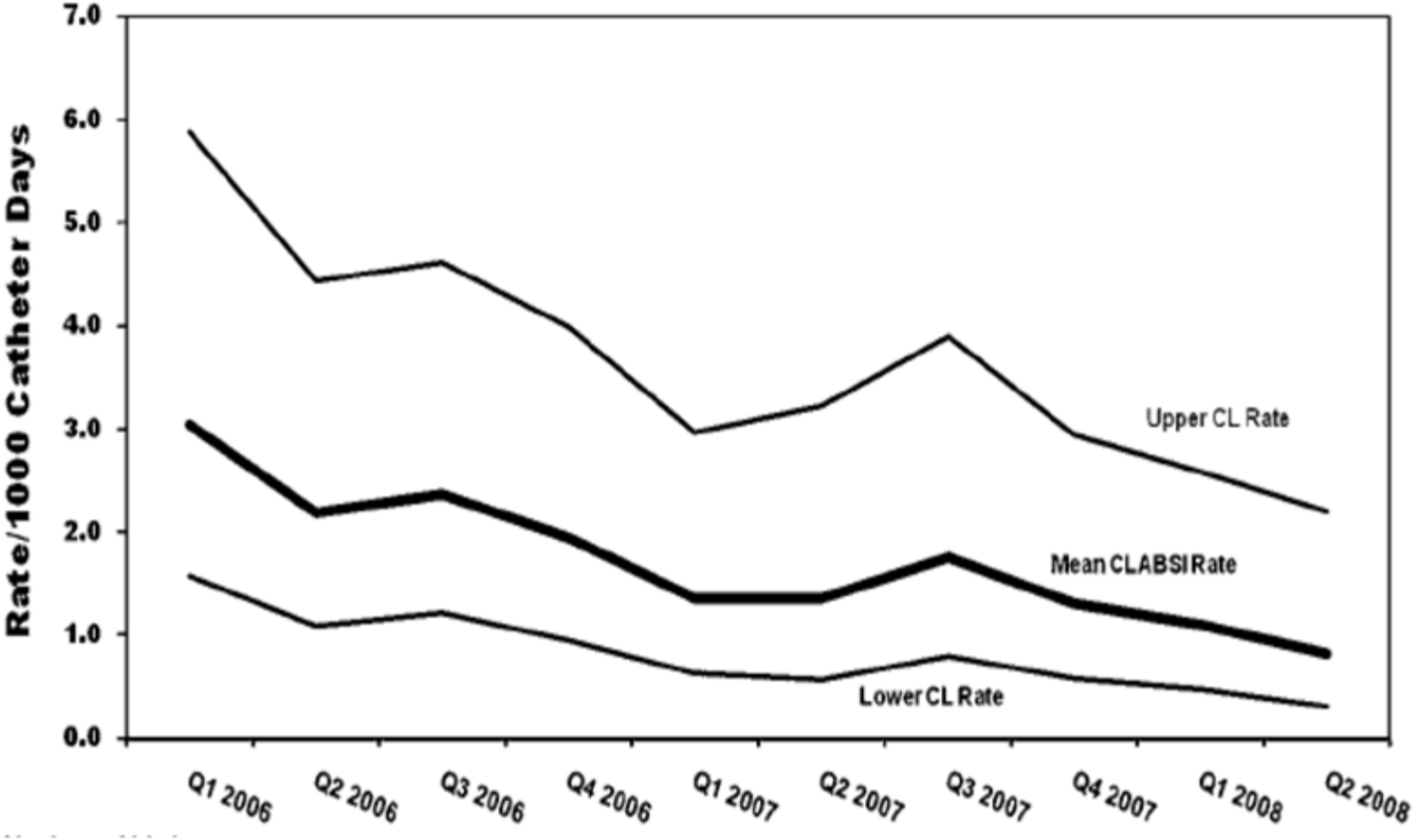
Impact of Statewide Quality Improvement Initiative on Hospital Mortality



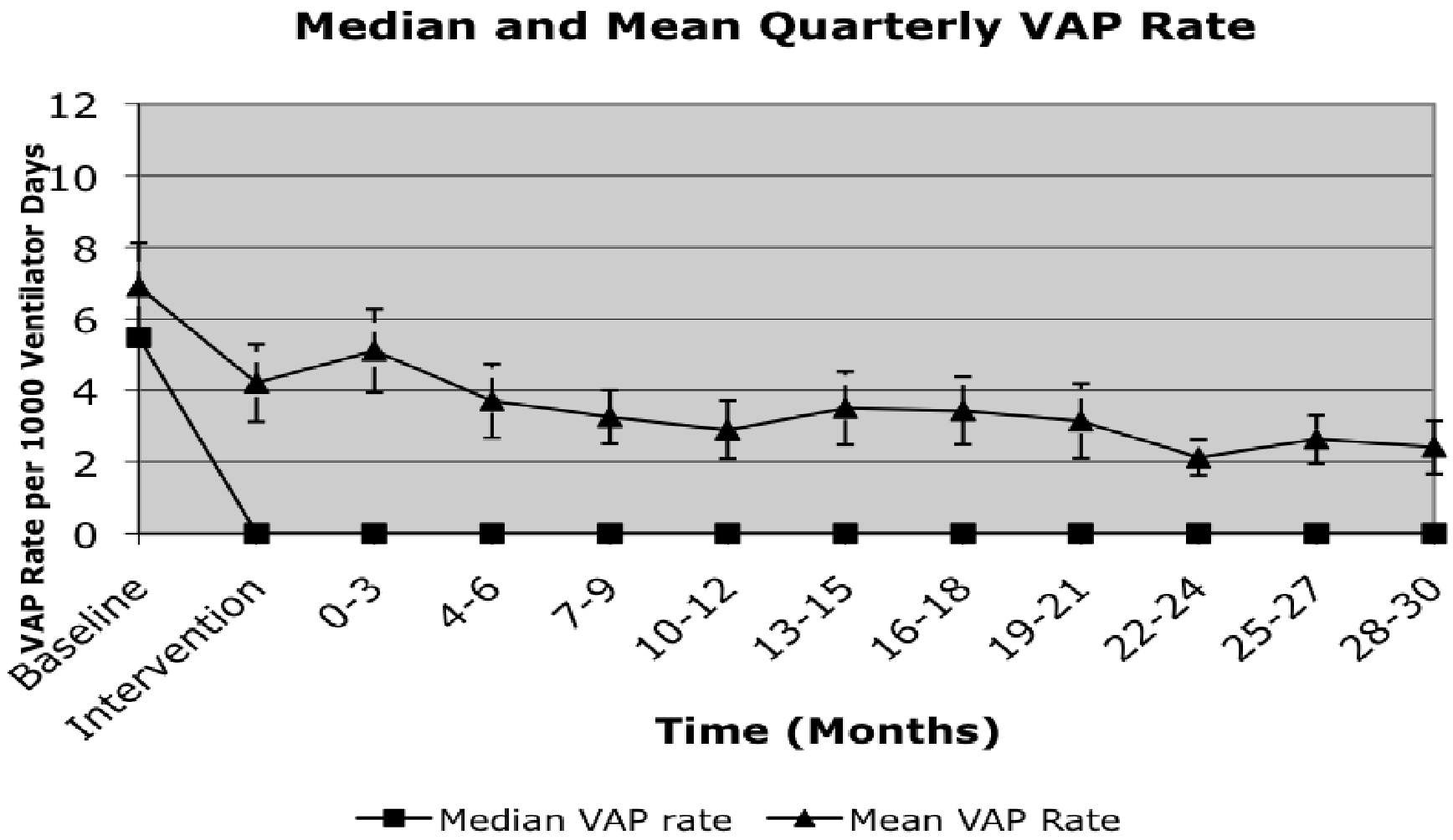
Lipitz: BMJ 2011

Rhode Island ICU CLABSI

23 ICUs representing 11 hospitals



VAP Rate Over Time



Yet We Have Much to Learn

Figure 5: CLABSI Rates Over Time

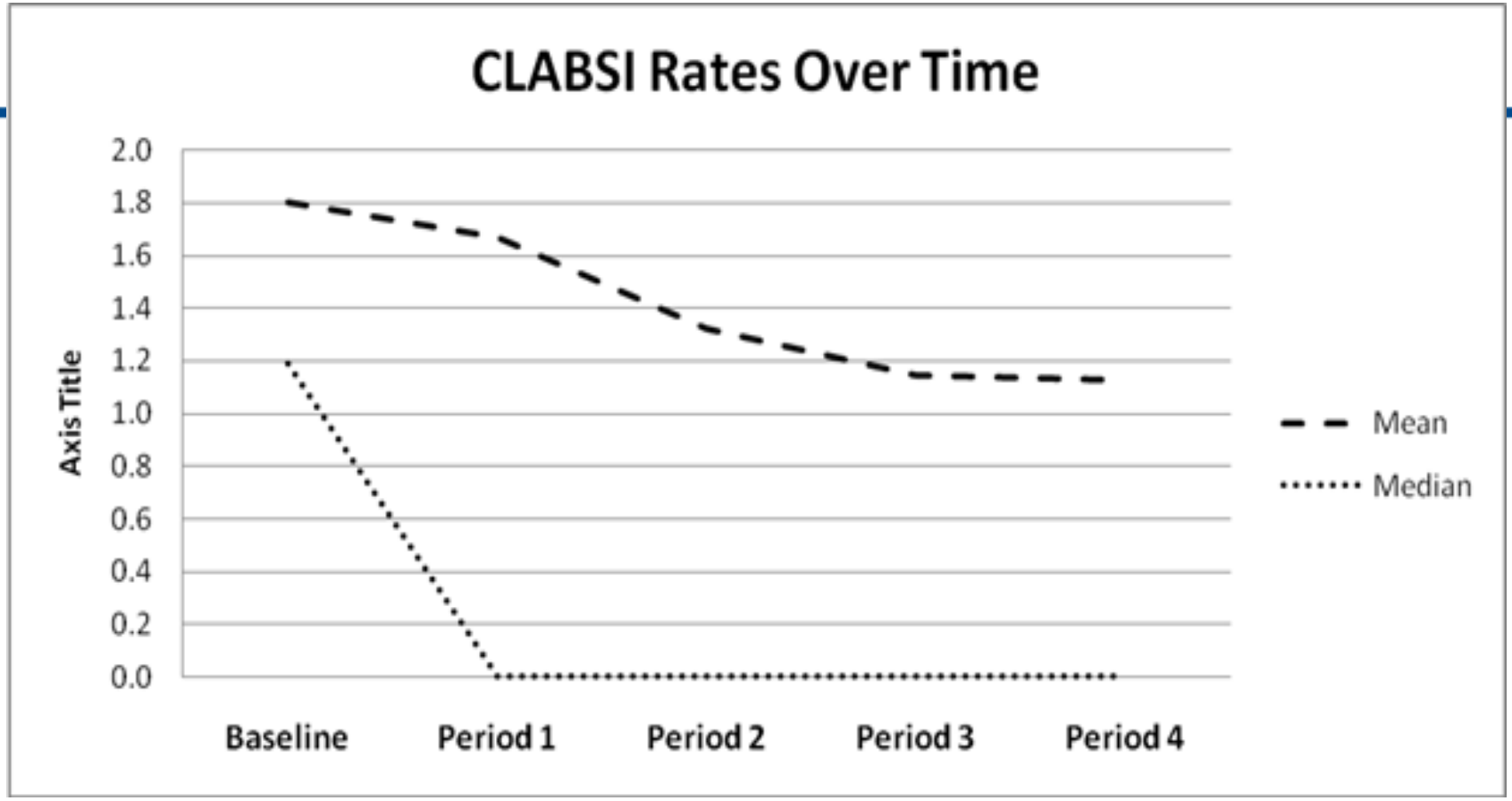


Figure 5 illustrates the changes in mean and median CLABSI rates across the data reporting periods. More than half of all participating units (n=402) reported zero CLABSIs in each reporting period since they began participating in the project.

For all adult ICUs participating in the first two project cohorts, rates have dropped from an average of 1.8 infections per 1,000 central line days to 1.17 infections per 1,000 central line days, an overall relative reduction of 35 percent

A Measure of Leader Engagement

State	# Hospitals in State	# Hospitals Enrolled	% Hospital Enrollment
Hawaii	18	16	89%
Tennessee	91	55	60%
Connecticut	27	15	56%
New Jersey	59	32	54%
West Virginia	52	23	44%
Ohio	138	57	41%
New Hamphire	26	9	35%
South Carolina	60	20	33%
Arkansas	72	23	32%
North Carolina	102	29	28%
Illinois	149	35	23%
Virginia	61	14	23%
Georgia	102	21	21%
Wisconsin	118	24	20%
Massachusetts	63	12	19%
Florida	121	19	16%
Indiana	101	14	14%
Missouri	113	13	12%
Pennsylvania	136	13	10%
Minnesota	99	9	9%
New York	134	12	9%
Nebraska	61	5	8%
Colorado	60	3	5%
Texas	376	14	4%
Oregon	57	2	4%

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Most patient safety challenges are not as easy as reducing CLABSI

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Practical Guidance ~ Learning through Clinical Communities

We can not do this work alone.. Interdisciplinary Science is needed

- Biologic - evidence-based practice
- Human Factors – identifying and mitigating barriers
- Psychological – adaptive challenges
- Sociological – clinical communities
- Economics – socio- economic incentives

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Clinical Communities for QI

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Need a firm case for change

- Unambiguous, credible evidence of the problem
- Significance of problem within context of competing priorities
- Targeted outcomes are clear and measurable

Key Attributes of Effective Clinical Communities

1. **Establish a small, strong 'integrating core'**
   - Communities are not "self organizing"
   - They need leadership and vision from the center
   - Coordination among multiple lead figures, with credibility among peers is vital
2. **Have a clear theory of change~ but are able to adapt**
   - A range of strategies and methods is available
   - These may need to be adapted to contexts and circumstances
   - Clinical communities should be 'light on their feet'

Effective Clinical Communities

3. **Identify and provide resources and training**

- QI is not always an organizational priority ~managerial support for time and resources required is important
- Training in QI methods and change management may be needed

4**. Deal with Conflict: Hold the Community together**

- Communities may be fragmented and conflict-ridden
- Often divergent views on evidence, measures

Effective Clinical Communities

5. Foster a sense of community

- A sense of ownership increases engagement
- The community defines the problem; identifies the solutions; holds themselves accountable

6. Collect and use data wisely

- Data need to be robust, comparable across teams, easy to collect, have face validity

Effective Clinical Communities

7. **Balance soft and hard tactics**

- Intrinsic motivation to improve quality is powerful tool
- Back it up with carrots and sticks
- “Holy Grail” is hard tactics that reinforce rather than undermine

8. **Recognize the importance of context**

- Organizations, professions, clinical disciplines have their own norms, routines, expectations
- Adaptability is crucial

The road to safer care is a long journey

There will always be:

- Successes and failures
- Stories to share
- New clinical challenges

We are more alike than different…

We can not do this work alone

As you continue the journey a reminder

COURAGE

“Never doubt that a small group of thoughtful committed citizens can change the world. Indeed, it’s the only thing that ever has.”

Margaret Meade

For More Information

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