Mentors for Quality

Flex Reverse Site Visit Breakout Session

July 11, 2019

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Flex Program in Alaska

- State of Alaska, Flex Coordinator Tricia Franklin
- ASHNHA – Contractor
- Mountain-Pacific Quality Health – Contractor

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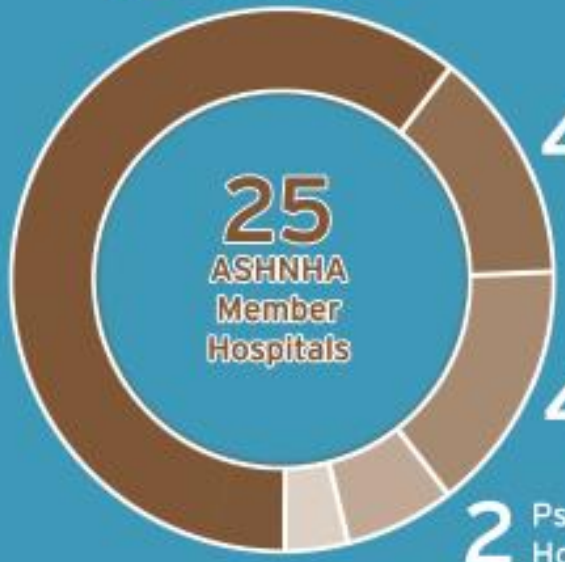
7 Tribally-owned Hospitals
(5 are Critical Access)

14 Critical Access Hospitals



4 Acute Care Hospitals

4 Sole Community Hospitals

2 Psychiatric Hospitals

1 Military Hospital

4 Standalone nursing care centers

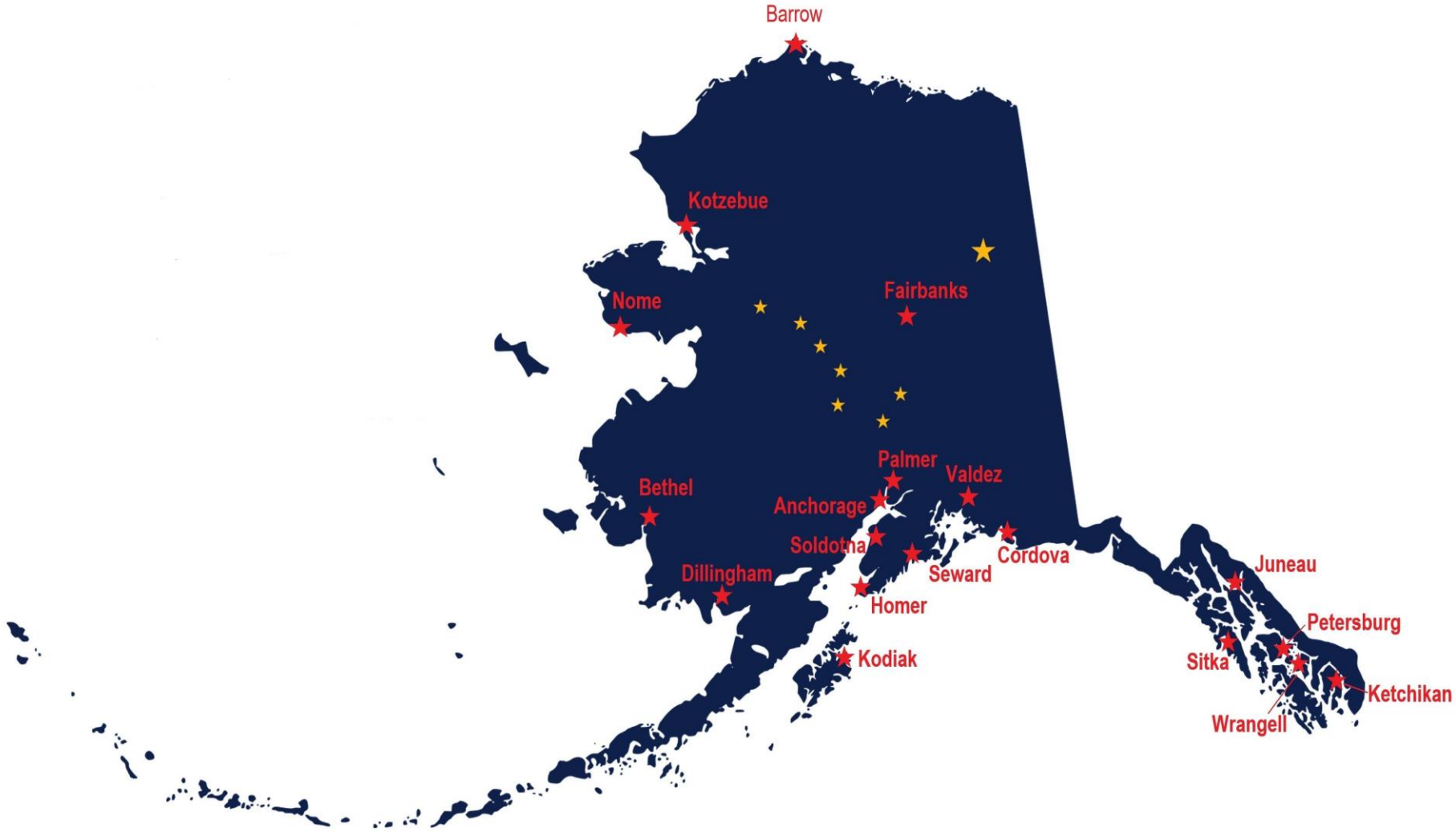
14 Nursing care centers co-located with Hospitals

2,772 Licensed Beds

Alaska Critical Access Hospitals (CAHs)

13 CAHs

Only 2 of the 13 have road access



Alaska Facts

en.wikipedia.org

- 586,412 square miles
- 737,438 population
- 8 of 10 communities not connected to road system

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Juneau – Capital of Alaska

Majority of communities are accessible only by air or water

Weather

Severe weather events happen frequently and can isolate a community

Other Forms of Travel

Alaskan CAHs – Air miles from Anchorage

ASHNHA Flex Activities

- CAH Site Visits
- CAH Monthly virtual calls
- In-person trainings
- Quality webinars
- Small Hospital Committee
- Patient Safety Committee
- CNO, CFO Collaboratives

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CAH Staff Challenges

- High staff turnover
- Staff wear many “hats”
- No one to train with at their hospital
- No quality experience, no Certified Professional in Healthcare Quality (CPHQ)

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Mentors for Quality Program Developed 2014

Objective 1.1 Assist critical access hospitals in implementing quality improvement activities to improve patient outcomes

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Mentors for Quality (M4Q) Purpose

To provide professional development to quality department leaders and staff by providing continued educational opportunities along with experienced peer mentoring.

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M4Q Overview

The ASHNHA Mentors for Quality program pairs more experienced patient safety leaders with less experienced staff from hospitals and long-term care facilities throughout Alaska.

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M4Q History

- 2014 Six pairs – five finished
- 2015 Eight pairs – four finished
- 2016 Eight pairs – three finished
- 2017-2018 Focus group
- 2018-2019 Current program – six pairs, all finished
- 2019-2020 - Beginning new group

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M4Q Program 2014-2016

- Model for Improvement/PDSA
- Kick-off meeting and training
- Calls every two weeks with the group
- Open to those at a hospital not in quality or infection prevention

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M4Q Challenges

- Staff retention during the project
- Bad pairing – night nurse can't communicate with mentor
- No leadership support
- Mentee has too many "hats"
- Project involves other staff that don't want to be involved

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M4Q 2018-2019 Program

- Six-twelve month mentorship
- ASHNHA pairs up those with similar job responsibilities
- Hospital leadership buy-in a must
- Weekly calls between mentor & mentee
- Develop a project
- Prepare for CPHQ exam with mentor assistance
- Attend monthly M4Q roundtable calls
- Prepare poster presentation

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M4Q Pairing

- First step to send out information about the program so you have a group
- Matching mentors/mentees
- Type of job (infection prevention)
- Interest in project
- Similar sized facility
- Tribal with Tribal

M4Q Project Selection

- Select meaningful quality improvement project
- Measurable outcomes
- Effect positive change

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Paperwork

- Letter of Intent
- Signed by CEO

ASHNHA 2018 Mentors for Quality Program
Facility Letter of Intent

_____(organization/facility name) desires to participate in the mentors for quality program. _____(name) would like to participate as a mentee/mentor (circle one).

The purpose of the program is to provide professional development focused on healthcare quality programs to quality department leaders and staff by providing continued educational opportunities along with experienced peer mentoring. Our focus is to set an example of exemplary quality in providing care to the communities we serve. See page 2 for more details about the 2018 program.

ASHNHA agrees to reimburse facilities for the following:

- One year NAHQ membership for mentee/mentor ($199)
- Preparation materials to study for the CPHQ exam if needed
- Travel support for either the mentee/mentor to participate in a site visit as the host or guest.
- Travel and any fees associated with preparing a project poster for display during the ASHNHA Annual Meeting September 25-27, 2018 in Girdwood Alaska, or a later ASHNHA/Patient Safety event or meeting

The participating organization agrees to the following:

- Support the individual to participate in ASHNHA sponsored group webinars/activities as they arise
- Support site visit travel to mentor/mentee facility
- Support CPHQ preparation and exam
- Notify ASHNHA if the selected individual leaves their position

CEO or Designee Signature:	
Name:	**Date:**
Hospital:	
Name of Mentee/Mentor	**Phone Number:**

Mentor Site Visit

- Chance to meet in-person
- QI project work

Date:_____

Project Title _____

(Name of Project Champion and Senior Leader Sponsor)

Aim & Background

Aim: (Including your How Good and By When statement)

Why is this project important?:

Run Charts

Make fonts large, title, labels, dates and notes very simple on graphs **prior** to shrinking graphs. Should be able to fit 6-8 readable graphs here.
If no data are available for a particular measures either create "empty" run list the name of the measure(s) to be collected.

Lessons Learned

(Enter summary here)

Changes being Tested, Implemented or Spread (some titled this Interventions)

- For each listed change, indicate whether it is being tested (T), Implemented (I) or Spread (S)

Recommendations and Next Steps

- Enter summary here (what do you need from Executive Project Champion, sponsor at this time to move project?)
- Recommendations
- Next Steps for testing

Team Members

(Names & Roles)

Sample Project

Poster Presentations

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Medication Scan Rate

PI Project / Mentors for Quality
Cathy Gross, Ginger Watko and Ann McGowan

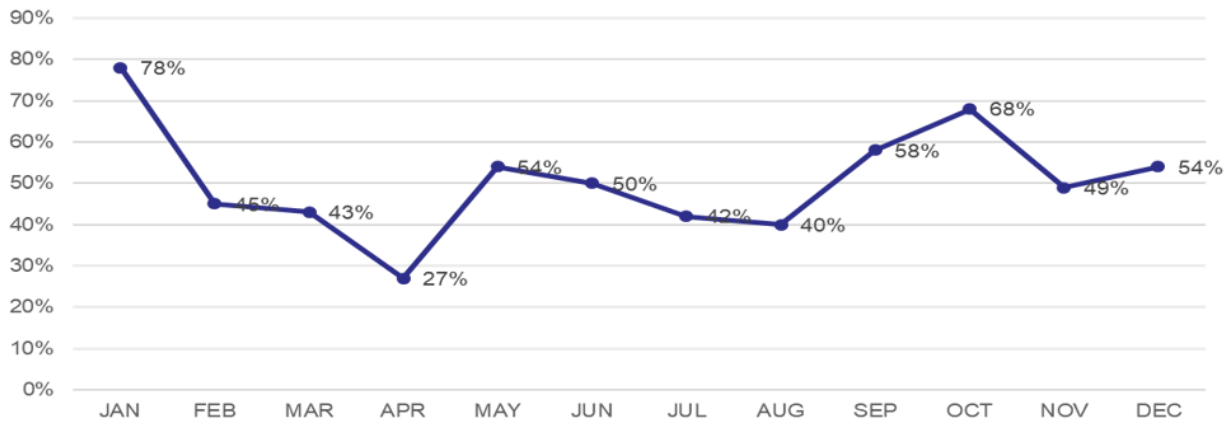
Goal & Background

Goal: WMC will achieve 75% medication scan rate compliance in acute care within a 4 month time period.

Why is this project important?

WMC's current medication administration process places patients at risk due to inconsistent practices.

% Med Scan Compliance Jan-Dec 2018



INTERVENTIONS

- Reviewed Our Process
- Surveyed Nursing Staff
- Set a goal at 75% compliance
- Observe Med Passes
- 1:1 Re-education for current staff
- Revised orientation for med scan
- Created a "fast-track" process for med scan issues
- Revised the Med Administration policy

Wrangell Medical Center
SEARHC CARE NETWORK

Lessons Learned

- We never truly got to the root cause of the med scan issues
- We found other pharmacy issues that took priority (our medication management issues were huge)
- Lack of pharmacy oversight/processes were needed
- Our ER med scan rates are not be separated from the IP/OBS and require manual review
- New travel staff impact our overall compliance rates
- We aren't so good at follow through

Recommendations/Next Steps

- Regroup, Revise, Recharge
- Find a Champion
- Beef Up our Med Scan Training
- Continue to Audit Med Scan Compliance
- Identify issues with follow through on projects

Team Members

Cathy Gross, RHIT, WMC PI Manager
Ginger Watko, RN, WMC CNO
Katrina Ottesen, RN, IT/Pharmacy Nurse
Blake Forrester, RN, Clinical Services Manager
Ann McGowan, RN, SEARHC PI Director

Sterilization FMEA

Kimberly Palmer, SEARHC & Coleen Fett, ANTHC

Start Date: August 2018

Aim & Background

By July 2019, proactively identify & mitigate three high risk potential failure points in the sterilization process

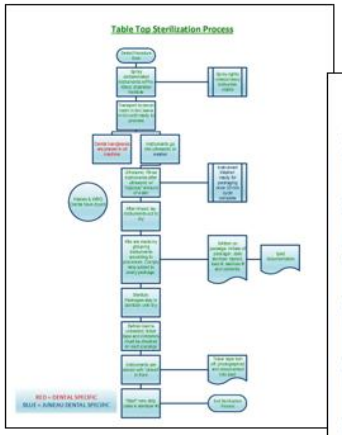
Why is this project important?

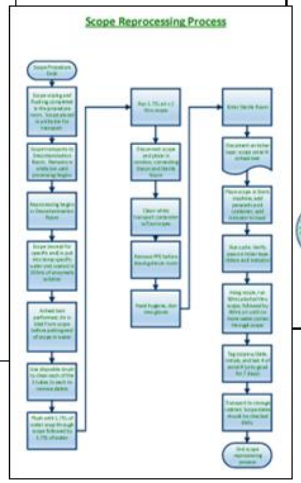
- Enhance patient safety by decreasing the risk of infection from critical or semi-critical medical devices
- High risk, high volume
- Complicated processes involving multiple people & steps

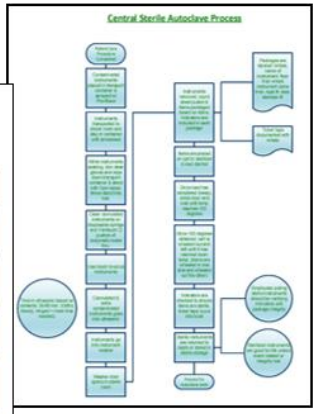
Team Members

Kimberly Palmer, PI Manager
Lisa Cone, Dental IC Trainer
Margarita Silva-Barber, IPC Manager
Jordan Snow, Central Processing
Kaitlyn Hull, Dental Assistant
Linda Cowan, Clinical Assistant
Roberta George, Dental Assistant
Grace Carson, Clinical Assistant
Chris Bue, Clinical Manager
Coleen Fett, Quality Mentor

Run Charts







Current Interventions/Changes being Spread

- Standardized competency for all staff involved in re-processing of medical devices to reduce variations in process
- Peel pouch standardization
- Adjustment of sterilizer settings
- Discontinuation of textiles during sterilization (Central Processing excluded)

Reflections

Lessons Learned

- Sterilization is an involved, complicated process
- Difficult to enforce changes without accountability
- Gains cannot be maintained long-term by workgroup
- Organization lacks strong policies preventing procurement outside of warehouse
- Start with fewer team members

Barriers Encountered

- Compliance is difficult to maintain with geographic spread
- Most staff with managerial oversight of these processes have little to no experience in HLD/sterilization

Recommendations and Next Steps

- Proposal of consortium-wide oversight role for sterilization
- Identify Infection Prevention "Champion" at each location to support ongoing compliance

SEARHC healthy is here.

ALASKA NATIVE TRIBAL HEALTH CONSORTIUM

ASHNHA ALASKA STATE HOSPITAL & NURSING HOME ASSOCIATION

Maniilaq Elder's Home in Kotzebue Alaska

Project Title: Resident Weights

Staff: Marcella Wilson-DON, Mary Willis-ADON, Val Kreil-ADM, Renee Legan-RD, and Harold Goode-CDM

Start Date: December 2018

Aim & Background

Within the next 6 months (May 2019) 100% of residents will have weights documented monthly.

Residents with a weight loss or gain of ≥ 5%, a weekly weight regime will be implemented on 100% of affected residents to help prevent unplanned weight loss or gain.

All residents will have no unplanned weight loss or gain by May 2019.

Why is this project important?

To maintain optimal health status related to nutritional intake.

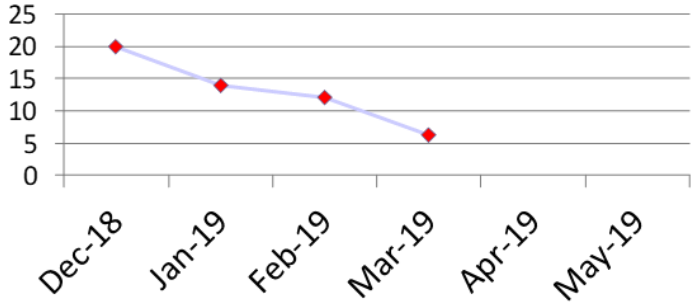
Changes being Tested, Implemented or Spread

Implement a system to ensure that all residents have a weight documented prior to the last day of the month.

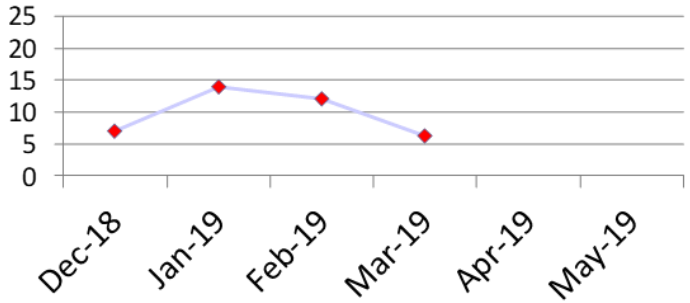
Weigh resident in a consistent manner every time.

Run Charts

% of **of residents with weight loss or gain of ≥ 5%**



% of residents with unplanned weight loss or gain of ≥ 5%



Mountain-Pacific Quality Health

UTUQQANAAT INAAT
A PLACE FOR ELDERS

Lessons Learned

We need to calibrate our scales monthly for accuracy.

We need to be more aware of resident's scheduled leave from the facility.

When recording % food eaten at meals, we need to be aware of food removed from plate that was not actually eaten.

Extra food & beverages served at activities and used as bingo prizes could contribute to weight changes.

Recommendations and Next Steps

- Audit - 100% of residents have a monthly weight recorded.
- Audit – 100% of weights recorded are corrected.
- Audit - 100% of residents with weight loss or gain of ≥ 5% will have weekly weights recorded.
- RD consult for 100% of residents with weight loss or gain of ≥ 5%.
- Dietary manager will perform food like and dislike interview for 100% of residents with unplanned weight loss or gain of ≥ 5%.

Increasing Survey Readiness

Start Date: June 4, 2018

Cordova Community Medical Center

SITKA COMMUNITY HOSPITAL

ASHNHA Alaska State Hospital & Nursing Home Association

Aim & Background

Background: Cordova Community Medical Center (CCMC) functions as a Critical Access Hospital and Long Term Care facility. These programs are surveyed for state licensure and CMS certification. CCMC does not have a survey readiness program and recent surveys resulted in preventable deficiencies. The organization wants to move from being reactive to survey findings to being proactive through monitoring the environment of care and correcting deficiencies as they are internally discovered.

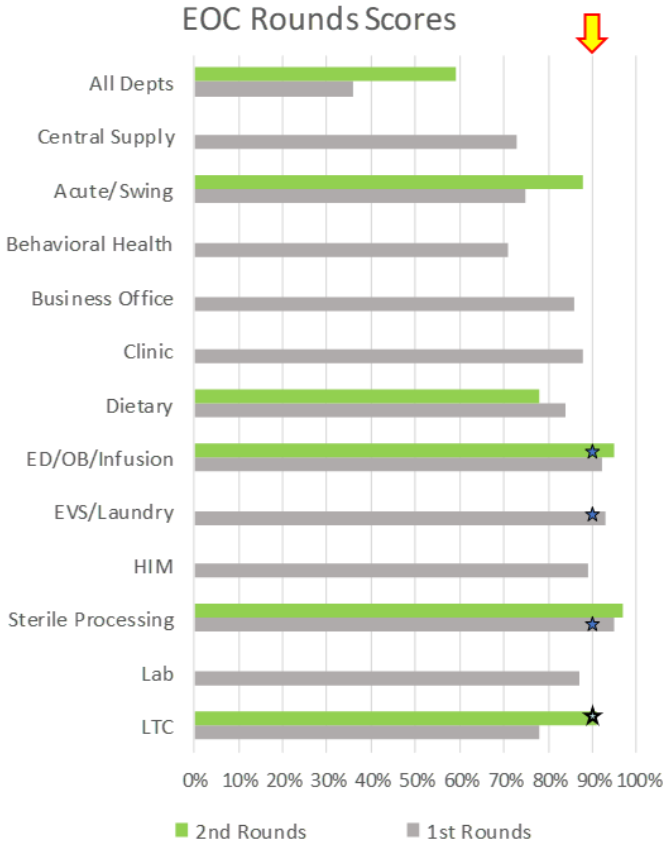
Aim: The purpose of this project is to increase survey readiness at CCMC by increasing environment of care (EOC) rounds scores by June of 2019:

- Full organization assessment from baseline of 36% to 75% compliance
- Department level assessment to strive for 90% compliance

Interventions

- Project planning started June 2018
- Develop EOC rounds checklist and schedule
- Establish EOC rounds team
- Establish all departments baseline score Educate organization on new process
- EOC rounds team attended Team STEPPS in August 2018
- Implemented iAuditor to complete rounds electronically and analyze data
- Analyzed responses for appropriateness in question applicability within and across departments to identify opportunities for the audit team to improve how they do rounds
- Update checklist to remove non-value added questions and add additional questions

Data Collection



Importance

EOC rounds monitors Life Safety practices, the environment of care, patient and resident safety, infection control practices, and staff competencies, which are all key safety elements in healthcare. This process supports survey readiness and regulatory compliance. The state/Federal survey in Dec. 2018 resulted in one finding in one area that could have be found during EOC rounds. This was a big success!

Lessons Learned

- Execute consistently (scoring and scheduling)
- Prioritize process, do not cancel rounds
- Must be positive and engaging and not feel punitive for staff participating
- Having a team doing rounds can be difficult to maintain so one dedicated person is essential
- Education and awareness needs to continue in between scheduled rounds for a dept
- Sharing results and following up on recommendations is necessary to improve compliance and safety
- In all but one dept., performance improved on the 2nd rounds (Dietary had no dedicated manager for a period of time between rounds)

Recommendations and Next Steps

- Target improvement initiatives around frequently failed items
- Engage Facilities Manager and/or Emergency Management personnel to join EOC Rounds Team
- Evaluate and update the schedule for completing EOC rounds to ensure at least one dedicated person can maintain the process (weekly, every-other week, monthly)
- Share data from iAuditor with Quality Committee and staff
- Implement process for ongoing EOC education (THE BIG 3 email or Safety board)

Team Members

Kadee Goss, Director of Nursing – LTC (CCMC)
Kelly Kedzierski, QI/IC Nurse & DON - CAH (CCMC)
Valerie Taylor, Quality Improvement Director (SCH)

Project Start Date 10/17/18

RCA² Implementation Bartlett Regional Hospital

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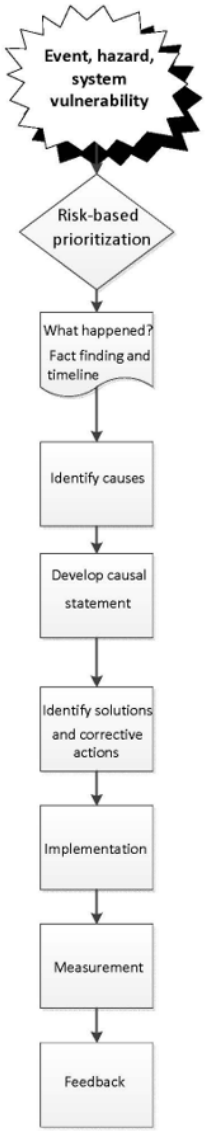
Aim & Background

We aim to improve the identification and implementation of improvements to systems-level vulnerabilities that lead to patient harm.

RCAs (Root Cause Analyses) have long been used in the investigation of sentinel events at Bartlett. In order to increase transparency and promote a culture of safety, a decision was made to implement RCA2 methodology. Establishing a consistent, non-punitive team method for investigating serious safety events, sentinel events, and near misses will lead to more rapid identification and resolution of systemic vulnerabilities.

Changes being Tested and Implemented

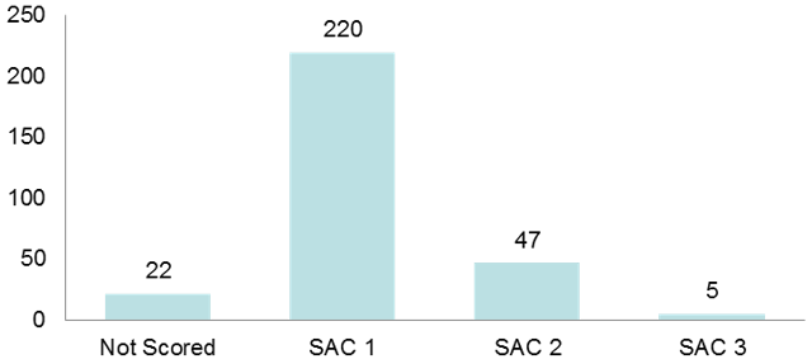
- Assess the Culture of Safety (done 11/2018)
- Become familiar with the National Patient Safety Foundation document "RCA²: Improving Root Cause Analyses and Actions to Prevent Harm" (done 11/18-2/19)
- Practice applying the SAC matrix (done 12/15/18- 3/1/19)
- Adapt occurrence reporting software system to track SAC matrix for each event (done 12/15/19)
- Practice RCA² on "near miss" events (12/18, 1/19, 2/19)
- Revise Patient Safety Committee Charter to include RCA² (done 3/12/19)
- Educate management team on RCA² (done 3/12/19)



Challenges & Lessons Learned

- The SAC matrix can be hard! Takes dialogue and practice.
- Find a sustainable way to imbed into organizational structure and culture.
- Slow and steady wins the race. The implementation of this is a marathon, not a sprint.

Occurrence Reports by SAC Score 12/15/18-3/15/19



Next Steps

1. Develop standard RCA² "packet"
2. Monitor progress toward inclusion of stronger action items

Next Goal: 90% of RCAs completed will identify "intermediate" or "strong" action items by 12/31/2019

Team Members

Sarah Hargrave, MS, RN, CPHQ, Director of Quality
Mary Crann, MSN, RN, Risk Manager
BRH Patient Safety Committee (under development)

Special thanks to Jill Blazier, Quality Director at Central Peninsula Hospital for her guidance and support as we implement this project!

central peninsula hospital | heritage place | serenity house

Bartlett Regional Hospital

National Patient Safety Foundation (2016). RCA²: Improving Root Cause Analyses and Actions to Prevent Harm. Available at: www.npsf.org

Sepsis Care Improvement
Bartlett Regional Hospital
Juneau, Alaska

ASHNHA — Alaska State Hospital & Nursing Home Association

Project Start Date 09/27/18

Aim & Background

We aim to improve sepsis care for all patients at Bartlett Regional Hospital by consistently meeting the Sep-1 measure at 52% by the end of 4Q 2019. The process begins with sepsis symptoms and recognition, and ends with the absence of signs/symptoms of sepsis.

When our team began this project the data pointed to antibiotic selection and timing as a priority area for improvement. Progress made toward decreasing the number of fallouts for this process is indicated on the run chart.

Tested (T) and Implemented(I) Changes

(I) RNs drawing 2nd blood cultures in the ED to save wait time on broad-spectrum antibiotic administration. 11/29/18

(T) MDs verbally communicate with RNs when antibiotic order placed 11/29/18

(T) Sepsis Case Review to provide case feedback to Providers and nursing directors 12/11/18

(T)Y-IV sites to avoid delay in 30ml/kg fluid resuscitation 01/10/19

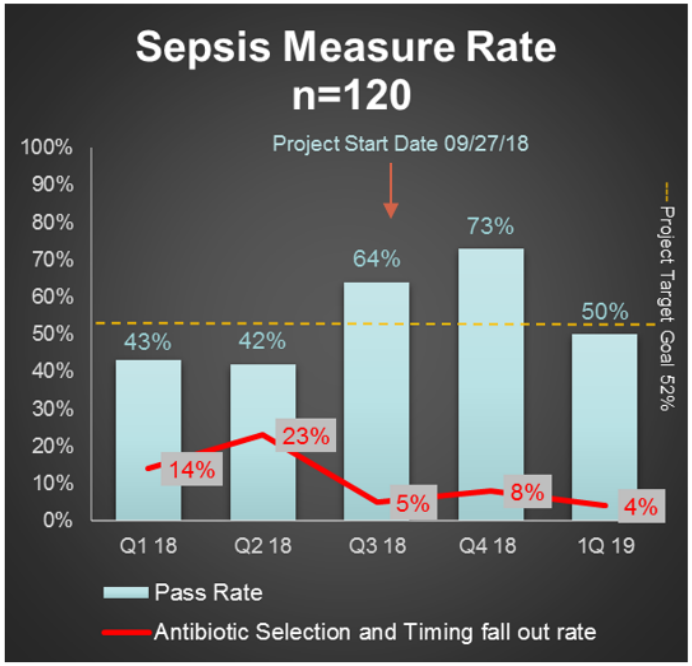
(I) Using a specific icon in the chart to mark patients who have or may have sepsis (01/10/19)

(T) Unit Directors to review sepsis cases with staff at monthly meetings (01/24/19)

(I) Pharmacist updated antibiotic list for use in ED sepsis cases (02/05/19)

(T) Incorporate crystalloid fluids documentation from EMS into the emergency department documentation (03/07/19)

Run Charts



Although the number of antibiotic fallouts has decreased, the overall Sepsis Measure pass rate has not been consistently rising signifying there are other processes in the system needing change.

Bartlett Regional Hospital

FAIRBANKS MEMORIAL HOSPITAL

Lessons Learned

Be mindful of possible subject-matter burnout with committee members

When it comes to "sticking to an agenda," occasionally it is okay to see where committee conversation leads—great change ideas can be born from this.

Heightened awareness, even without process changes can briefly improve patient safety. *Sustainability of this improvement only comes after systems changes are made.*

Even though process change is vital, the human element (case review with staff for heightened awareness of sepsis process/treatment) should not be downplayed.

Recommendations and Next Steps

Sepsis Case Review forms will be routinely filled out and sent to department directors and physicians. All cases will be shared at monthly staff meetings.

Sepsis measure rates and cases will be monitored monthly.

Initiating PI project for nurse-to-nurse handoff and exploring the application of Team STEPPS principles during the handoff period.

Small tests of change must continue to be made until statistically significant change is realized in the data.

Team Members

Dr. Bea Brooks ED Quality Champion
Dr. Keegan Jackson SEARHC Clinic
Liz Bishop, RN, Director Med Surg/Infusion
Kim McDowell, RN, CEN, Director ED
Audrey Rasmussen, RN, CCRN, Director CCU
Sarah Hargrave, MS, RN Senior Director Quality
Charlee Gribbon, RN, BSN, CCRN IP
Jennifer Twito, RN CPS, ER/CCU
Chris Sperry, Pharmacist
Kris Brockman, LAT, ATC, CPHQ, CPPS
Deborah Koelsch, MSN, RN Quality

ASHNHA

CERTIFICATE
OF RECOGNITION

Coleen Fett

Mentors for Quality 2019

In recognition of your dedication to improving patient safety and quality by serving as a mentor.

ASHNHA

Date

ALASKA STATE HOSPITAL & NURSING HOME ASSOCIATION

Becky Hultberg
CEO/President

Mentors for Quality 2016 Kick-off


Mentors for Quality
2019 Certificates and
Recognition
CROWNE PLAZA

Questions?