HRET HOSPITAL IMPROVEMENT INNOVATION NETWORK (HIIN)

COFFEYVILLE REGIONAL MEDICAL CENTER | PATIENT SAFETY

ORGANIZATION AND TEAM

COFFEYVILLE REGIONAL MEDICAL CENTER
Coffeyville, Kansas

Coffeyville Regional Medical Center
www.crmcinc.org

Quality Improvement Team

Sarah Hoy, Senior Director of Quality

Abby Lickteig, Quality Improvement Nurse

Pilar Davis, Infection Prevention Nurse

Jennifer DeRosa, Medical Staff Coordinator

SETTING THE STAGE

>> Patient safety and accountability to quality improvement is not a new idea to hospitals. The push for better measurement and accountability from projects like the Kansas Hospital Engagement Network (KHEN) has brought to light many areas for improvement. Often times in the smaller hospital it is the squeaky wheel that gets the grease, but sometimes there are low volume issues that can represent significant potential for harm. The KHEN helped to shift our focus to patient safety projects like CAUTI, Early Elective Delivery, Falls, etc.

>> This presentation will focus on our journey to eliminating early elective deliveries (EED), decreasing and eliminating CAUTI and significantly patient falls and eliminating falls with injury. The biggest challenge in meeting patient safety goals is staff buy in, both frontline and providers as well as finding workable policies that tie together evidence based care and frontline practice. Effectiveness and efficiency are both keys to buy in!

>> This challenge was worth tackling for patient safety! Our mission is to provide our patients and their families with the highest quality healthcare and this includes a sharp focus on patient safety.

ADDRESSING THE CHALLENGE

>> Addressing the challenge with hard stop policies, education and positive energy towards the goal resulted in a significant decrease in Early Elective Delivery. In fact, we adopted the hard stop policy in April 2013, and we have had only one EED since that time.

>> CAUTI – We increased awareness and provided mandatory education to our nurses. We instituted a process that requires reviewing Foley necessity every shift and new interventions for peri care.

>> Falls – In 2016, we set a steep goal for reducing patient falls by 50% in one year. We kept close watch on fall risk assessments done on admission and fall risk interventions in place. We added a new "yellow" light indicator with the nurse call system that alerts the team to a fall risk without entering the patients room.

>> Sustainability is the key to the EED and CAUTI project now. Fall prevention is an ongoing QI project with PDSAs cycles and process improvement until we have outcomes to sustain.

PROJECT DESIGN

>> At the beginning of the project, CRMC had many of the same long-term OB physicians for over 20 years. This led to many of the members of the community having certain expectations regarding deliveries particularly with the topic of induction of labor. Many women in our small community had induction of labor for elective reasons in the past and expected to continue this practice as did the physicians that were providing the care.

>> CAUTI – New interventions and tracking results

>> Falls – New admission risk assessment, new call light intervention along with other interventions such as gait belts, bed and chair alarms.

>> Sustainable success! Only one EED since April of 2013! CAUTI days between incidence as high as 653 Days! And a 25% reduction in total patient falls from 2015-2016 with no major injury to patients related to falls in 2016!

RESULTS

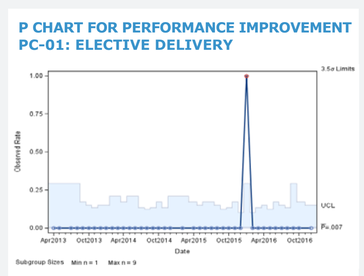
>> The HEN was instrumental in giving us the "nudge" we needed to push for action. CRMC had reviewed EEDs multiple times, but the networking, support and education that came from the HEN/KHEN were key to our success in actually driving change. The success of the EED Reduction efforts are a source of pride in quality improvement at CRMC. The hospital team including frontline staff as well as medical providers are very pleased with the data and jointly achieved success. Patient satisfaction was considered with this project. One of the biggest concerns of implementing this hard stop policy was whether or not we could retain patients. The patients have taught us that they will support our patient safety efforts by continuing to use our services.

>> CAUTI sustainability is an additional source of pride for the nursing staff. We have achieved 653 Days between events and continue to strive to break that record!

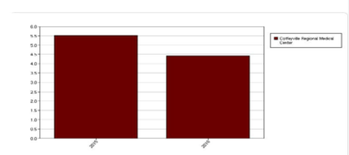
>> Falls, although we didn't reach the goal of a 50% reduction in 2016, achieved a 25% decrease and continues to have an active, engaged team committed to use evidence based practice to improve the outcomes at CRMC.

RESULTS

P CHART FOR PERFORMANCE IMPROVEMENT PC-01: ELECTIVE DELIVERY

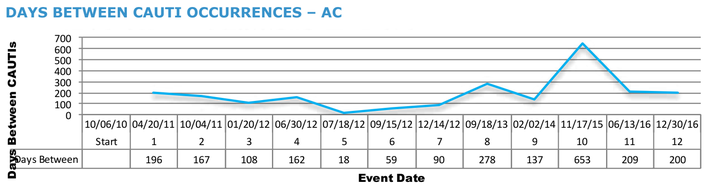


PT FALLS WITH OR WITHOUT INJURY



(Number of patient falls/Total number of patient days) x 1000

DAYS BETWEEN CAUTI OCCURRENCES – AC



	10/06/10	04/20/11	10/04/11	01/20/12	06/30/12	07/18/12	09/15/12	12/14/12	09/18/13	02/02/14	11/17/15	06/13/16	12/30/16
	Start	1	2	3	4	5	6	7	8	9	10	11	12
Days Between		196	167	108	162	18	59	90	278	137	653	209	200

LESSONS LEARNED

>> Just do it! It is hard to take the first step, especially if that step is a hard stop policy, obtaining frontline staff buy in or convincing the team that you are leading a worthy cause… but once the process gets started, and success begins, it is much easier to continue good results!

>> Elimination of early elective deliveries, reducing and eliminating CAUTI and decreasing patient falls particularly injury falls help CRMC to be a safe and efficient place to receive healthcare by placing a focus on decreasing patient harm events.

SPREAD AND SUSTAINABILITY

>> Fairly simple for spread on EEDs. The hardest part of the EED reduction was medical staff buy in so that the policy can be implemented and enforced. Patient education was also an important aspect so they will have a better understanding of why this is so important. We used our childbirth classes to educate.

>> Spread was more difficult with falls. At times, we are combatting a culture that accepts "we did all we could" and that is where repetition and teaching the team to utilize all the resources available to them comes in to play.

>> CAUTI results with implementation of required interventions in the electronic health record was an easier spread as well. When the documentation is required to complete your record, the team is forced to address it.

>> Transparency is key, provide graphical results along with evidence based research to further support this mission. Sharing results with the team promotes sustained improvement! We started GEMBA data boards in 2016 to increase communication and transparency.

HIINPROVEMENT

>> All patient safety projects need commitments from every hospital. With health care changing everyday we face new challenges and new quality improvement initiatives. The need for continuous improvement should always be top priority to ensure patient safety.

>> "Will you/your hospital join me in the commitment to preventing harm with a proactive approach to improvement and engagement?"

Kansas HEN 2.0 Best of Show Award
Advancing Maternal Safety 2016