thequalitypost

in this issue

Monthly Quality Improvement Newsletter for the **Division of Hospital Medicine**

November 2015 • Issue 59

Greetings from Michelle, Nader and Sasha

QUALITY IMPROVEMENT
DIVISION OF HOSPITAL MEDICINE

Welcome to the 59th edition of The Quality Post. In this issue we feature a piece on sustaining QI and provide an update on the holdover improvement project. We also present information on UBLT efforts, a new discharge dashboard and data on our 4+1 metrics.

Sustaining Quality Improvement

It is often after a QI initiative has achieved success that the project team thinks about how to sustain this success. Instead, sustaining change should be a part of project development. Here are some key factors behind ensuring success over time:

-Design standard work so that the intervention is not dependent on the practice pattern or creativity of the current personnel.
Example: Care Partners observed several unit clerks entering RN names/numbers into the Apex treatment team in order to determine the most efficient method.

-Enforce standard work as part of the job. When an initiative is viewed as a "pilot" there is a temptation to mentally prepare for an endpoint. Instead, ongoing accountability is key. Sometimes enforcing the change takes the form of standard work embedded in the electronic medical record.
Example: "Nebs No More" created an order set for converting nebulizers into MDI's automatically.

-Ongoing audit and feedback: timely, accurate, actionable data not only supports the intervention but also sustains awareness.
Example: The QI newsletter you are reading right now!

-Embed fun and praise into the intervention: use appropriate humor to add levity to a challenging task, recognize high-performing groups.
Example: The memorable slogan for the telemetry project was "man's greatest foe" and it stuck with residents even when the posters came down.

-Create a mechanism for training new personnel on standard work. This is especially important at a teaching hospital with new trainees every year.
Example: The medication reconciliation training video is easy to show at future noon conferences.

-Plan ahead for succession of ownership. This is critical for projects with leaders who are residents - when they move on to fellowship, the initiative can falter.
Example: The residents in the HSL program often carry the torch for the graduating class above them.

The 4 Questions to Ask When You Debrief on a Project

Debriefings can help you accelerate projects, innovate new approaches to problems, and hit difficult objectives.

More than a casual conversation about what did and didn't work, a debriefing digs into why things happened. It should review four key questions:

1. What were we trying to accomplish? Start by restating the objectives you were trying to hit.
2. Where did we hit (or miss) our objectives? Review your results, and ensure the group is aligned.
3. What caused our results? This should go deeper than obvious, first-level answers.
4. What should we start, stop, or continue doing? Given the root causes uncovered, what should we do next, now that we know what we know?

Adapted from "Debriefing: A Simple Tool to Help Your Team Tackle Tough Problems," by Doug Sundheim.

Updates in Holdover Improvement

Starting last fall, Sumant Ranji, Jonathan Duong, Trevor Jensen, James Harrison and a team of others began a project to improve the holdover signout process at UCSF. They began by conducting a two-part needs assessment, including a cross-sectional observational study and focus groups, to identify opportunities for improvement.

① Why does this matter

- ~40% of all admissions to our teaching service are holdovers
- DHM Safety culture survey results in 2013 revealed room for improvement around shift changes/transfers
- Informal feedback from residents and attendings revealed considerable frustration with current holdover process

② What do we know from the literature?

Most literature on handoffs relates to day to night transfers & little is known about the educational value of handoffs

Common themes across studies:

- Handoff Environment
- Standardization and Uniformity
- Designated Transfer of Care/Accountability
- Information Transfer
- Closed loop Verification
- Perceptions/Acceptance/Satisfaction

③ What is the goal of the improvement project?

Maximize the utility of the **face-to-face** handoff by improving the:

Efficiency
Educational Value
Safety

④ What did we learn from the needs assessment observations and focus groups?

Observed 61 holdover signouts

(Including both floor and ICU patient handoffs)

Key Results:

For all observed holdovers:

- The median holdover signout duration was 14.3 minutes (range: 7.3 - 43.0 minutes).
- Teaching moments from team members occurred in 32.8% of holdovers.
- Immediate constructive feedback occurred for 0% of holdovers.

For a subset of observed holdovers:

- The median resident presentation lasted 13.4 minutes (range: 5.4 – 21.3 minutes).
- The patient data portion, all of which can be found in our electronic medical record (EMR), made up a median 8.3 minutes (57.0%) of the entire holdover signout.

Focus Groups

Question: What are provider perceptions of safety, efficiency and education within the holdover signout process?

Format: Focus groups & structured interviews with interns, residents, hospitalists, leadership

Participants agreed that:

- Holdover signout is often inefficient due to repetition of information and poor logistics
- Safety concerns were common (e.g. unclear code status and severity of illness, delays in seeing patients, and poor med rec)
- Formal education was rarely present
- Holdover signout should use several best practices previously identified in the signout literature (e.g. quiet location, minimal interruption, and verification of understanding and to-dos)
- **Most favored creating a standardized format that minimizes presentation of objective data that is available in the chart**

Updates in Holdover Improvement

⑤ The Intervention

STANDARDIZED HOLDOVER FRAMEWORK

BEST PRACTICES: During Holdover Sign-out with night animal

Roles & Expectations:

Accepting Team Members:

- Pull up primary data for review (CXRs, CT, labs) on computer
- Review urgency (ask when patient was last seen and how well the night animal knows them)
- Clarify degree to which home med list has been reviewed & reconciled
- Verify/input orders to reflect plan (diet/fluids, ppx, antibiotics)
- Bring up time-sensitive decisions for consults, procedures & imaging
- Confirm code status order and quality of the discussion
- Update team designations, 1st call providers, and attending
- Restate major to-do items for the day

Attending:

- At the beginning: Call attention to time (Keep presentations to <7 minutes)
- Prioritize discussion of HPI & clinical reasoning over objective data
- At the end, emphasize night resident learning & educational points:
  Provide Feedback & **ASK:** *What questions came up for you overnight?*

⑥ Progress to Date

Initial Messaging Launch (August)

- Emails to attendings, senior residents & night hospitalists
- Framework Posters in M989
- Wiki page
- Pocket Cards
- In-person meetings (Intern report & Faculty lunch)

Ongoing:

Distributed via morning signout emails

⑦ Current Challenges

- Lack of awareness (particularly amongst housestaff)
- Computer availability
- Residents don't see holdover signout as a problem
- Lack of role modeling
- Lack of audit and feedback/measurement strategy & resources

⑧ We want your feedback for the next phase of the improvement effort!

- What has been your experience with using the framework with your team?
- What ideas do you have for the next phase of this improvement effort?
- How can we overcome our current challenges?
- How can attendings help message this?

Special thanks to the Holdover Improvement team.
Please feel free to contact Sumant Ranji with any questions, comments, or concerns.

UBLT Update

CPI Quality and Safety Improvement Cycle Aug-Oct 2015

The 14M/L, 9/13 ICU, and PICU UBLTs focused on reducing C Diff rates during this most recent CPI Improvement cycle. The inter-UBLT collaboration along with support from our partners in the UCSF Infection Control & Hospitality Departments made this an incredibly rich learning cycle.

What were our results?

We don't have October data yet, but our last reported case of hospital-onset CDI on 14M/L was on August 12, 2015!

Next Steps

- Partnering with Infection Control on updating educational materials to hardwire the gains made during this cycle.
- Working with hospitality to increase the number of audits/QA checks on rooms with CDI patients.

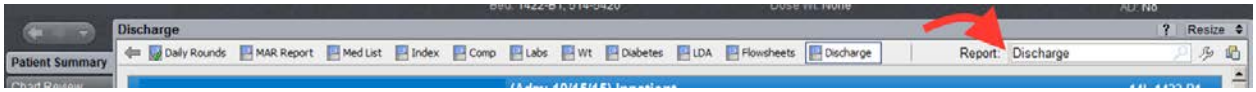
CPI Value Improvement Cycle Nov-Feb 2016

Our next improvement cycle will focus on Value. UBLTs across UCSF are working to reduce "Cost per Case." We will be devoting this cycle to exploring ways to remove waste and reduce LOS.

For those going on service in the coming months, look out for a survey to help us gather data on our most common delays that contribute to increased LOS.

New Apex Discharge Dashboard

Have you ever wished there was a place in Apex where you could see all of the key information related to preparing your patient for discharge on one screen? Thanks to Andy Auerbach, Michelle Mourad and others there is now a Discharge Dashboard in Apex where medicine teams, case managers, and bedside nurses can easily share key information related to discharge planning.

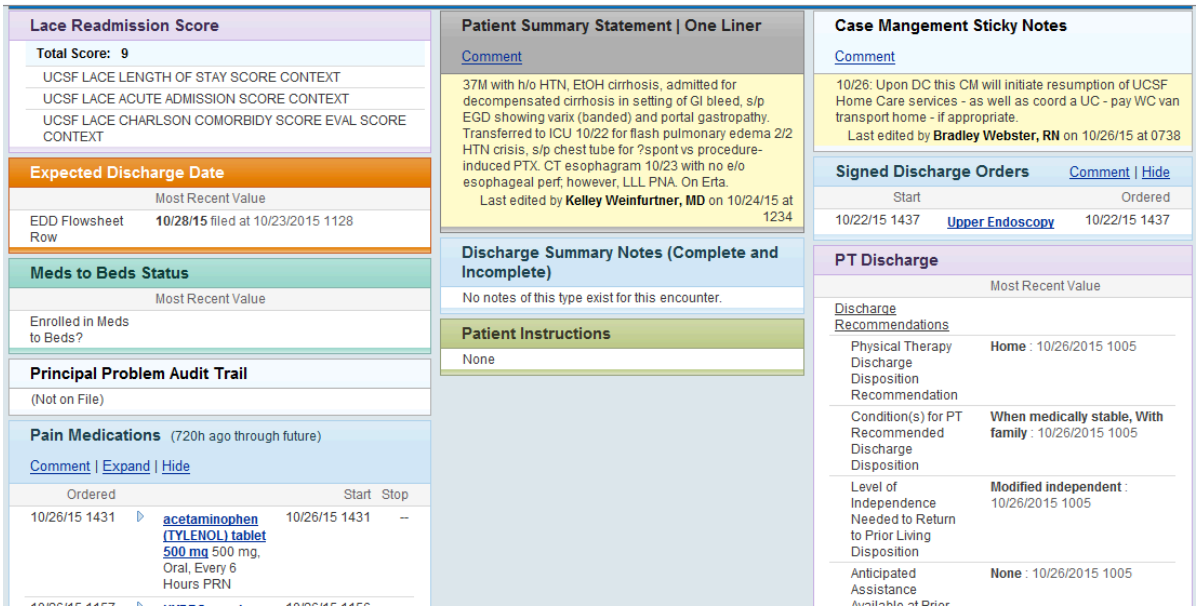


How can you access it?

1) go to the patient summary tab
2) search discharge in the reports field
3) find the dashboard and wrench it in

How can you use it?

1) Pull it up on rounds
2) Use it to set expectations with your team about the elements of a high-quality AVS
3) Teach your team to review it the day before you plan on discharging a patient and consider using it at tee time



DHM/Residency "4+1" Priorities

Four Core Metrics:

Achieve ≥ 75% score for HCAHPS Communication MD "Explained in Understandable Way"							7 of 12 months					
FY2015 Baseline	**July**	**Aug**	**Sept**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**Jun**
74.9%	72.5	**80.0**	**82.1**									

Sustain number of total phlebotomy draws by achieving ≤ 1.7 sticks per hospitalized patient per day							6 of 12 months					
FY2015 Baseline	**July**	**Aug**	**Sept**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**Jun**
1.7	**1.56**	**1.51**	**1.51**	1.64								

Achieve ≥ 90% of patients who have had all medications reconciled before discharge							4 of 12 months					
FY2015 Baseline	**July**	**Aug**	**Sept**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**Jun**
77.7%	76.5	86.7	84.3	88.9								

Achieve ≥ 20% of hospital medicine discharges by noon							8 of 12 months					
FY2015 Baseline	**July**	**Aug**	**Sept**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**Jun**
20.1%	**20.4**	16.0	15.7	17.7	**26.3**							

Plus One Metrics:

Achieve ≤ 23% of patients on telemetry until discharge (with LOS > 48hrs)							6 of 12 months					
FY2015 Baseline	**July**	**Aug**	**Sept**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**Jun**
22.6%	**23.0**	24.2	23.6	29.0								

Achieve ≥ 75% patients with High-Quality AVS							6 of 12 months					
FY2015 Baseline	**July**	**Aug**	**Sept**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**Jun**
74.4%	65.1	69.1	62.0	65.0								

Achieve C Diff rate of ≤ 11.1 (per 10,000 patient days)							6 of 12 months					
FY2015 Baseline	**July**	**Aug**	**Sept**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**Jun**
9.23	16.8	**6.26**	**9.05**									