

Fostering engagement and improvement through leadership at the gemba

Meredith Foxx
Lisa Yerian



Us



Meredith



Meredith Foxx
Executive Chief
Nursing Officer
Cleveland Clinic

Lisa



Lisa Yerian, MD
Chief Improvement
Officer
GI and Liver Pathology
Cleveland Clinic

Why must healthcare change?

- Too expensive
- Safety and quality inadequate
- Poor access
- Global pandemic and staffing shortages
- Caregivers carry a tremendous burden

How?

Cleveland Clinic



- Nonprofit academic medical center
- 6,496 beds in 21 hospitals in US, UAE, UK
- 10M outpatient visits
- 1921: Founded by physicians *“to act as a unit”* → *Clinician led*
- 72,000 **caregivers** (*“everyone is a caregiver”*)
- *best place to receive care anywhere and the best place to work in healthcare*

“Culture of Improvement”

every caregiver
capable,
empowered
and expected
to make
improvements
every day



Our Improvement Model

- Developed, tested, refined by us
- Roadmap to create a culture of improvement – “*every caregiver, every day*”
- everywhere, for everyone and by everyone

What matters most?

How are we doing today?

What gets in the way?

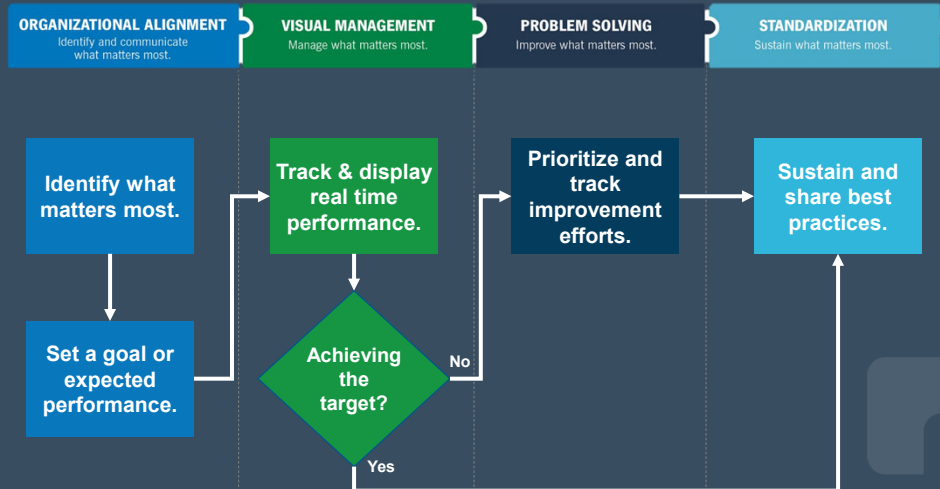
Do we use the best known way?

ORGANIZATIONAL ALIGNMENT Identify and communicate what matters most.	VISUAL MANAGEMENT Manage what matters most.	PROBLEM SOLVING Improve what matters most.	STANDARDIZATION Sustain what matters most.
<p>LEADING LEADERS</p> <ul style="list-style-type: none"> Set strategy, aligned with our enterprise goals. Continually share a common, clear and consistent vision of your area's purpose and future. Build alignment. Discuss what matters most with patients and caregivers. 	<p>LEADING LEADERS</p> <ul style="list-style-type: none"> Visit with patients and caregivers to see, hear and confirm what matters most. Reinforce what matters most and the desired behaviors that support our culture. Respond to meaningful changes in drive-and-watch metrics. 	<p>LEADING LEADERS</p> <ul style="list-style-type: none"> Help build team problem-solving skills. Provide time to improve work. Provide focus on the problems that matter most to all stakeholders. Create a psychologically safe environment for caregivers to share information in support of highly reliable processes. 	<p>LEADING LEADERS</p> <ul style="list-style-type: none"> Go and see standard principles and desired behaviors in your area. Ensure processes are designed for all caregivers to be successful. Ensure diversity of representation in all activity.
<p>LEADING TEAMS</p> <ul style="list-style-type: none"> Translate leadership's vision. Establish metrics and objectives for team's success. Align daily work to enterprise goals. Create alignment. Routinely ask patients, senior leaders and team members what matters most. 	<p>LEADING TEAMS</p> <ul style="list-style-type: none"> Advance improvements through sharing and discussing drive-and-watch metrics with your team. Foster team participation in identifying and solving problems. Use today's discoveries to improve tomorrow's performance. 	<p>LEADING TEAMS</p> <ul style="list-style-type: none"> Foster a safe environment and teamwork. Discuss problems and errors openly with empathy to enable learning. Share improvements. Ask questions that help the team discover root causes. Use data. Encourage experiments. 	<p>LEADING TEAMS</p> <ul style="list-style-type: none"> Confirm standard processes are maintained and followed. Establish an environment that supports all caregivers speaking up about safety, quality, experience and equity issues. Reduce unnecessary variation.
<p>AS PART OF A TEAM</p> <ul style="list-style-type: none"> Connect your work to local and enterprise goals. Understand how your work impacts patients and others you work with. Identify your process measures that support Cleveland Clinic's goals. 	<p>AS PART OF A TEAM</p> <ul style="list-style-type: none"> Huddle often. Track measures for all to see. Learn from the metrics and improve your work. Communicate as a team. 	<p>AS PART OF A TEAM</p> <ul style="list-style-type: none"> Identify and improve activities that don't add value or could go wrong. Use team problem-solving process to eliminate waste and drive improvement. Innovate through small and large changes. 	<p>AS PART OF A TEAM</p> <ul style="list-style-type: none"> Identify and document the current, one best way to do a job. Take responsibility for following standards each and every time. Share and improve standards through the PDCA process.
<p>TOOLS</p> <ul style="list-style-type: none"> Leverage our enterprise mission and goals to guide your work. Use the Goal Setting: OKR Guide (Objective and Key Results) and view the Performance Management - OKR Video at Connect Today. Create drive-and-watch metrics. 	<p>TOOLS</p> <ul style="list-style-type: none"> A step-by-step video tutorial is available at Visual Management Tutorial. Utilize the Drive-Watch dashboard to monitor performance. Use the tiered huddles to identify, address and share issues. 	<p>TOOLS</p> <ul style="list-style-type: none"> Use the five improvement questions and Plan-Do-Check-Adjust (PDCA) process. Use Kaizen cards and boards to share and prioritize problems. Solve problems using Just Do It (JDI), Root Cause, or Complex (63) approaches. 	<p>TOOLS</p> <ul style="list-style-type: none"> Establish and confirm standard work. Follow regulations, standards and policies that apply. Use available checklists each and every time. Utilize Process Confirmation to ensure we follow our most critical processes.

21-002-2169911 | ©Cleveland Clinic Foundation 2021

www.clevelandclinic.org/improve

CCIM Overview

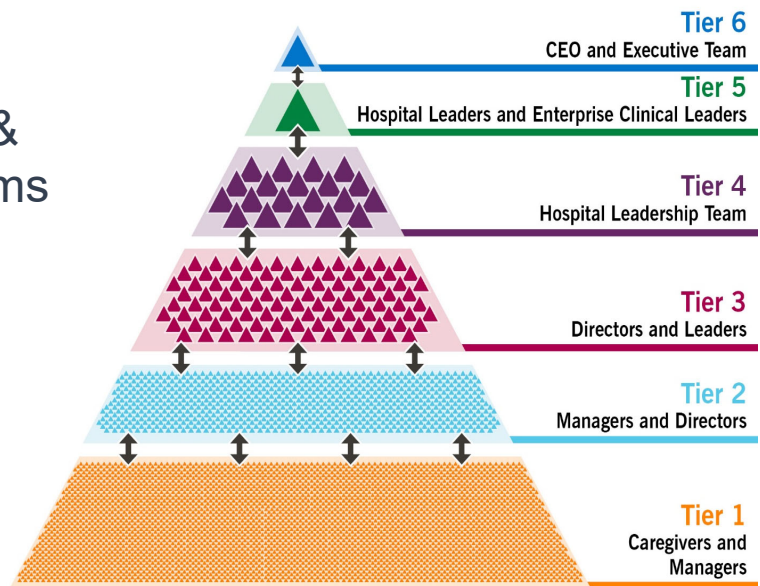


ORGANIZATIONAL ALIGNMENT



Tiered Daily Huddles

- Foster culture of safety, teamwork & embracing problems
- Build operational awareness at all levels
- Support our caregivers



OUTCOME METRICS VS PROCESS METRICS



Resides higher in the organization



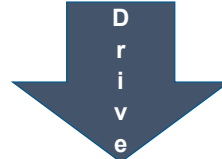
Often delayed in measurement



Resides closer to frontline and is close to real-time



If we do this well, outcome is good



WATCH METRICS VS DRIVE METRICS



Responsible for



Doing pretty well



Action needed if performance changes significantly



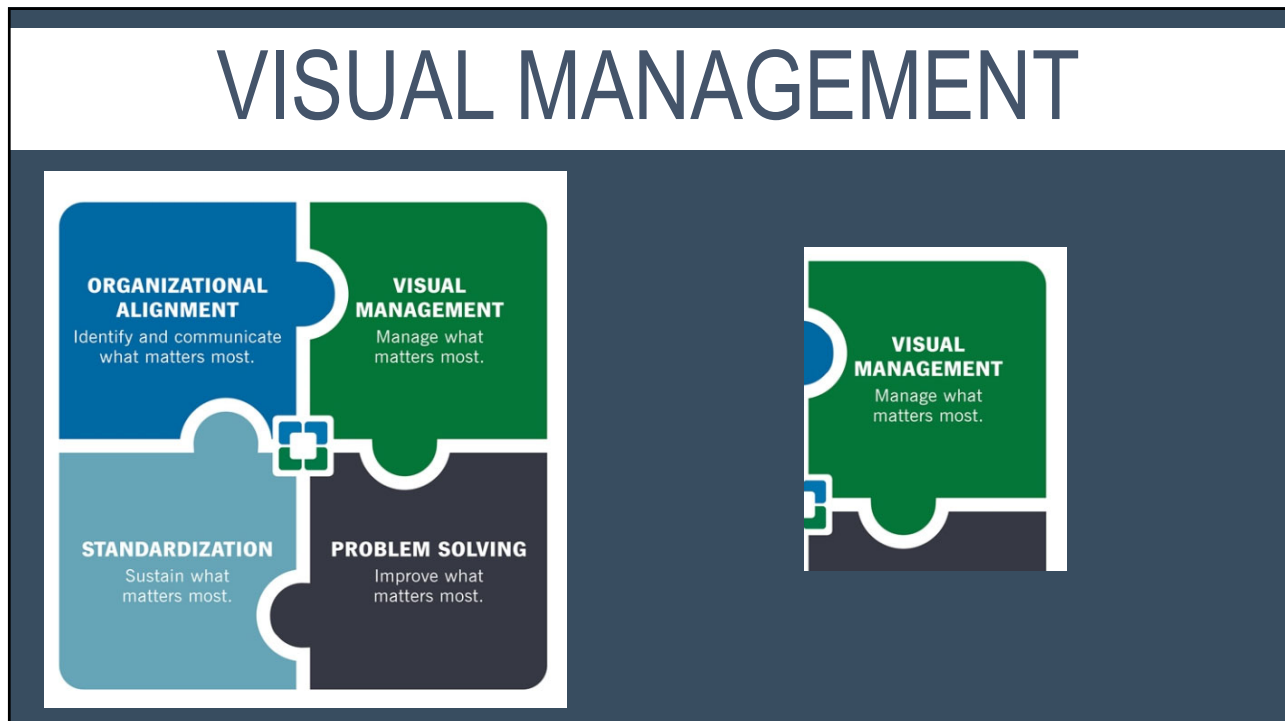
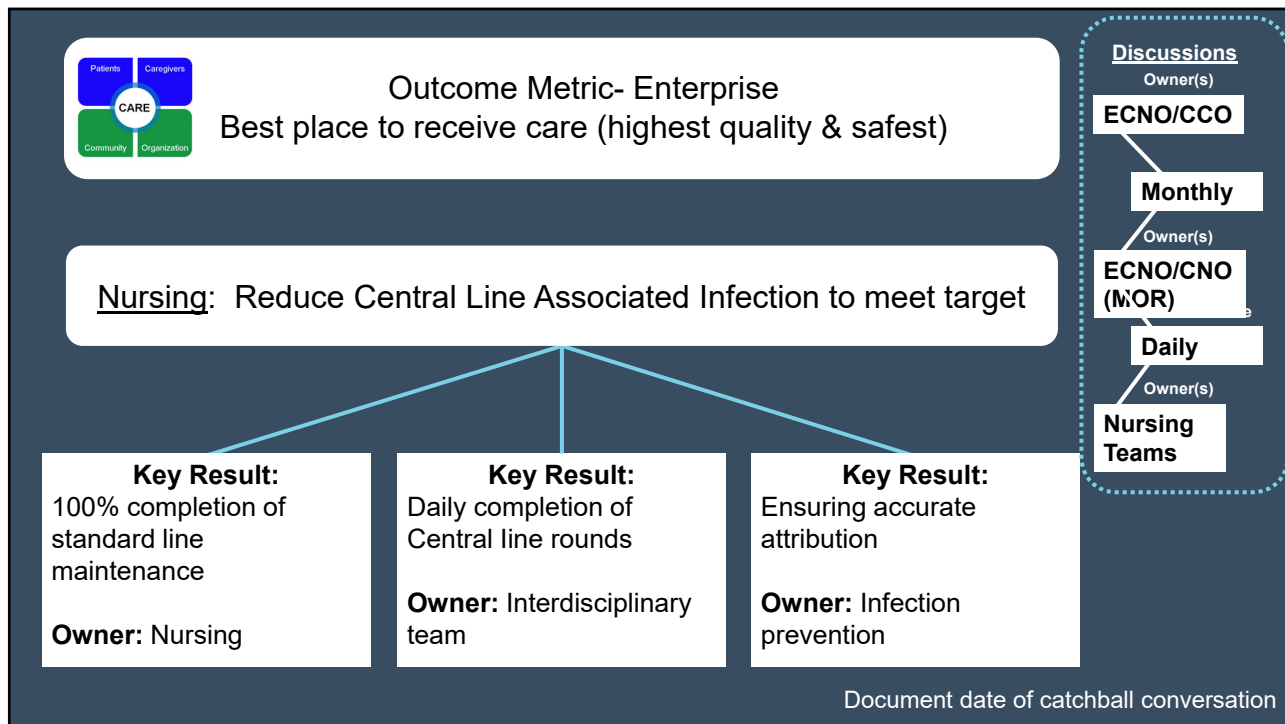
What matters most



~3 metrics



Actively driving improvement

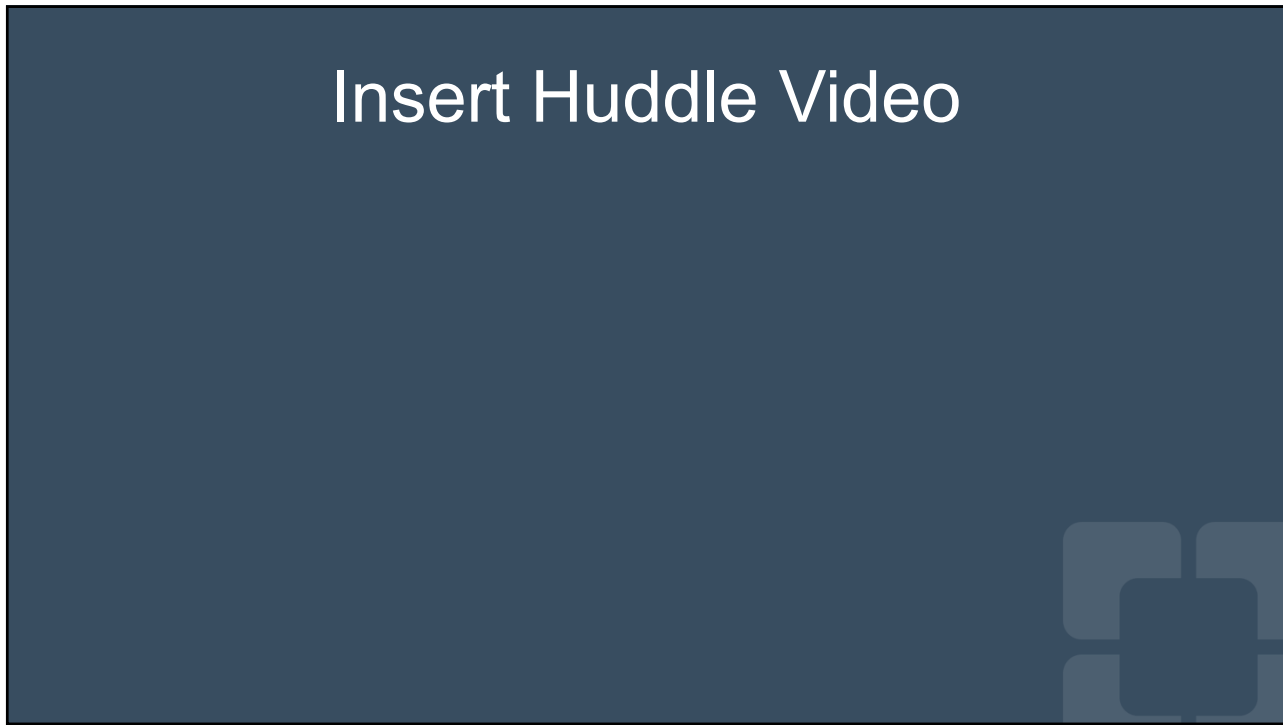


Cleveland Clinic **Cleveland Clinic Improvement Model (CCIM)**
 Harnessing the Power of Every One to Achieve Our Goals

ORGANIZATIONAL ALIGNMENT Identify and communicate what matters most.	VISUAL MANAGEMENT Manage what matters most.	PROBLEM SOLVING Improve what matters most.	STANDARDIZATION Sustain what matters most.
<p>SENIOR LEADERS</p> <ul style="list-style-type: none"> Set strategy, aligned with our enterprise goals. Share a common, clear and consistent vision of your area's purpose and future. Build alignment. Discuss what matters most with patients and caregivers. <p>MANAGERS</p> <ul style="list-style-type: none"> Translate leadership's vision. Establish metrics and objectives for team's success. Align daily work to enterprise goals. Ensure alignment. Ask patients, senior leaders and team members what matters most. <p>ALL CAREGIVERS</p> <ul style="list-style-type: none"> Connect your work to local and enterprise goals. Understand how your work impacts patients and others you work with. Identify your process measures that support Cleveland Clinic's goals. <p>TOOLS</p> <ul style="list-style-type: none"> Leverage our enterprise mission and goals to guide your work. Use the Strategic Agenda Management (SAM) and performance management tools at the ONE HR Portal. Identify drive metrics. 	<p>SENIOR LEADERS</p> <ul style="list-style-type: none"> Visit with patients and caregivers to see, hear and confirm what matters most. Reinforce what matters most and the desired behaviors that support our culture. Recognize positive outcomes and remove obstacles. <p>MANAGERS</p> <ul style="list-style-type: none"> Post and review drive and watch metrics with your team. Foster team participation in the process. Ensure the process drives improvement. <p>ALL CAREGIVERS</p> <ul style="list-style-type: none"> Huddle often. Track progress and post for all to see. Learn from the metrics and improve your work. Communicate as a team. <p>TOOLS</p> <ul style="list-style-type: none"> A step-by-step video tutorial is available at Visual Management Tutorial. Create and maintain a world-class Visual Management Board. Use the tiered huddles to identify, improve and share issues. 	<p>SENIOR LEADERS</p> <ul style="list-style-type: none"> Help build team problem-solving skills. Provide time to improve work. Provide focus on the problems that matter most. Create a safe environment for caregivers to share information in support of high reliability processes. <p>MANAGERS</p> <ul style="list-style-type: none"> Promote teamwork. Discuss problems and errors openly with empathy to enable learning. Share improvements. Ask questions that help the team discover root causes. Encourage experiments. <p>ALL CAREGIVERS</p> <ul style="list-style-type: none"> Identify and discuss activities that don't add value or could go wrong. Use team problem-solving process to eliminate waste. Innovate through <p>TOOLS</p> <ul style="list-style-type: none"> Follow the Plan (PDCA) process. Use green cards and boards to share and prioritize problems. Solve problems using Just Do It (JDI), Root Cause or Deming's 7 approaches. 	<p>SENIOR LEADERS</p> <ul style="list-style-type: none"> Embed standard principles and desired behaviors in your area. Understand current standards prior to creating new standards. Make improvement part of the everyday work for everyone. <p>MANAGERS</p> <ul style="list-style-type: none"> Confirm standard processes are maintained. Make standards visible. Recognize and address deviations right away. Learn from and adjust to deviations from standards when appropriate. <p>ALL CAREGIVERS</p> <ul style="list-style-type: none"> Identify and document the current, one best way to do a job. Share, follow and improve standards through the PDCA process. <p>TOOLS</p> <ul style="list-style-type: none"> Use the online 5S tutorial. Use the 5 Improvement Questions to improve caregiver and patient experience.

> Use the tiered huddles to identify, improve and share issues.

Every caregiver capable, empowered and expected to make improvements, every day.
 Intranet portals.ccl.org/improve | E-mail improve@ccl.org | Internet ccl.org/improve | Twitter [#thecclm](https://twitter.com/thecclm)



Huddle Debrief

- What went well?
- How would you coach this team if you were Meredith?

What makes visual mgmt. Ideal?

- What matters most- OKRs
- How are we doing today- Professional Practice Model huddle board
- Who are we taking care of
 - What is current state: patient volume/occupancy

When I don't see it

- Explicitly ask:
- What are you and the team focused on?
- How do you know if you are doing well or not?
- What is the biggest opportunity for improvement?

What does the organization need to know on a daily basis?



*Quality & Safety (patients & caregivers)

Patient & Caregiver Experience

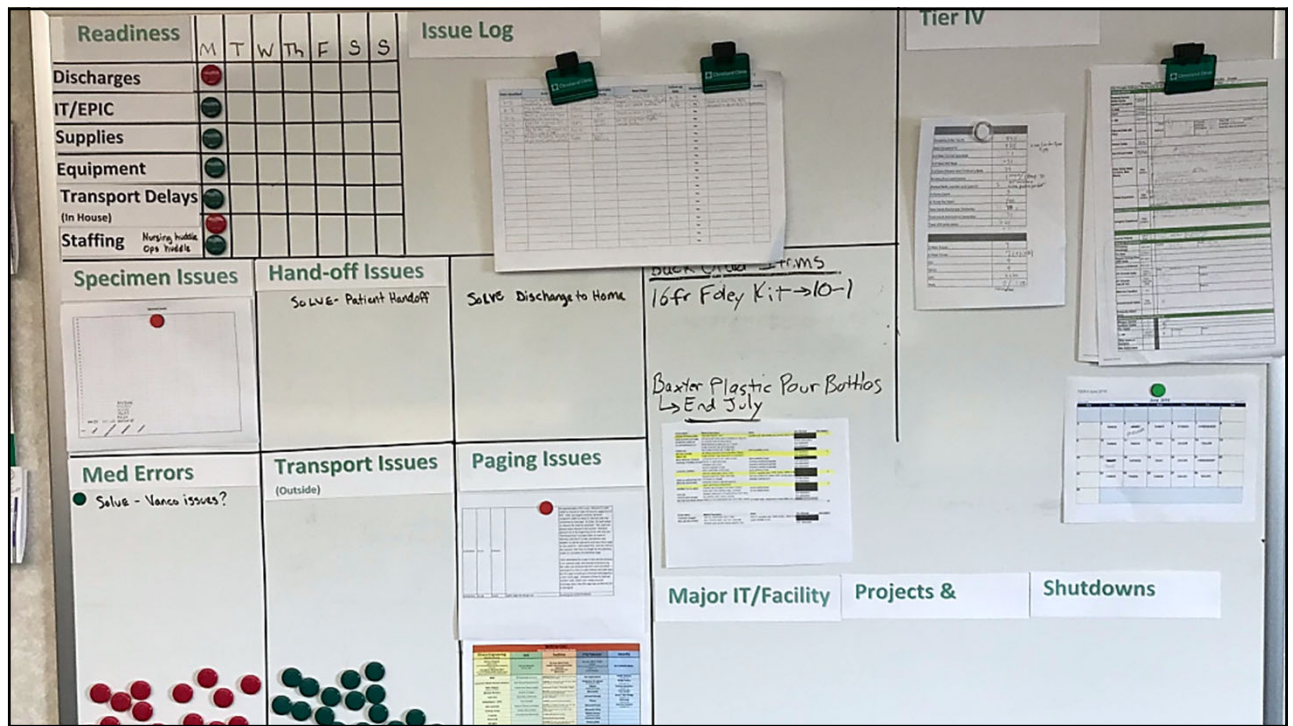
*Volume / Throughput / Capacity

*Staffing

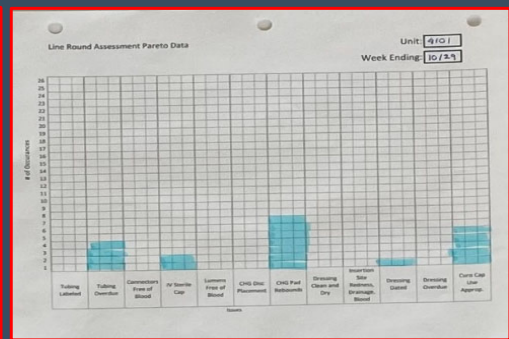
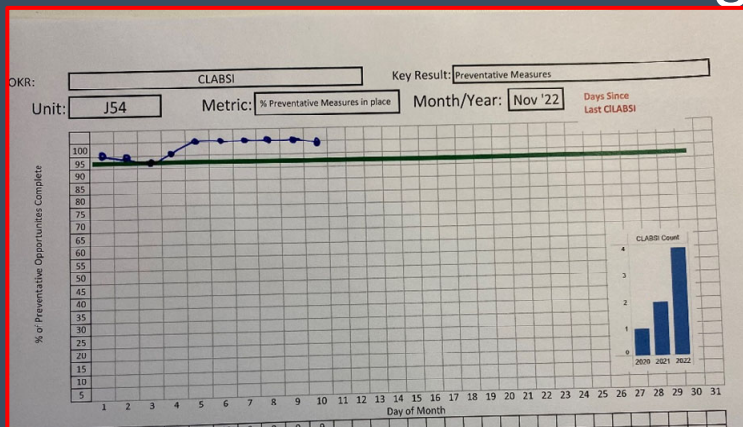
Other: Issues, Announcements

Action Items / Follow-ups

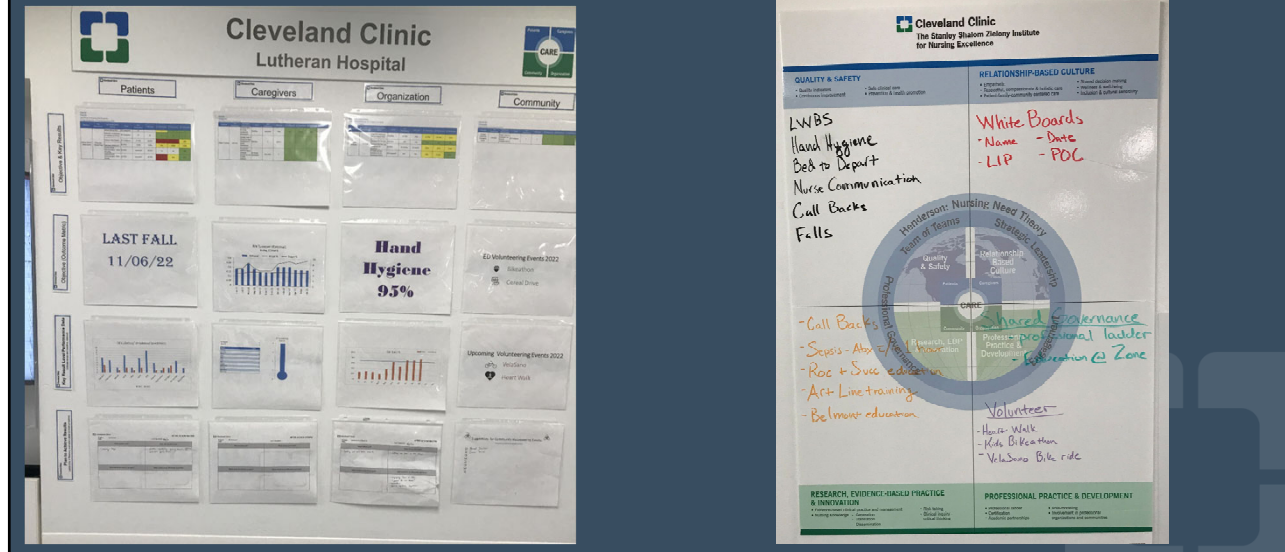
*Metric based



Visual Mgmt



Visual Mgmt- metric specific focus



What makes a huddle run?

STANDARD



Agenda



Tools



Behaviors

<p>CLABSI</p> <ul style="list-style-type: none"> Type of line/how long has it been in? Type of organism Likely source: <ul style="list-style-type: none"> Insertion – occurred within 7 days of a new line Duration/Location – site selected or duration of time in that location (>14 days) may have caused the infection Maintenance – CHG bath documented daily? Dressing integrity maintained? Oozing at site? Access – Adherence to scrub the hub/use of Curoc caps Definition – infection could likely be sourced elsewhere 	<p>Falls</p> <ul style="list-style-type: none"> Patient assessed at a high fall risk? (Y/N) <ul style="list-style-type: none"> If no – was this the appropriate assessment Fall assisted? (Y/N) Physiologic fall? (Y/N) Injury sustained? (Y/N) If high risk, were the following interventions in place <ul style="list-style-type: none"> Bed Alarm and/or Chair Alarm BR Assistance “within arm’s reach” My Safety Plan complete Hourly Rounding How long to respond to the call light or bed alarm?
<p>CAUTI</p> <ul style="list-style-type: none"> Duration of Foley Type of Organism Culture appropriate to send – symptoms present of fever, pain, leukocytosis? (Y/N) UA sent first to confirm bacteria present? Foley changed prior to sending the culture? Proper sampling supplies used? - vacutain (Y/N) 	<p>Code Blue</p> <ul style="list-style-type: none"> Significant safety issue? <ul style="list-style-type: none"> If yes, changes to telemetry, pulse ox, RR prior

COACHING QUESTIONS

Enterprise Tier 5 Huddle

how are we doing today?

Tier Huddle		Huddle Date	Category	Tier Huddle																											
Tier 5		2/16/2023	(All)																												
		CCHS	FL	OH	Reg	ACMC	AG	ALL	AV	EU	FHCs	FV	HL	LU	MC	ME	MM	MMC	SP	UN	IR	MN	MS	MT	WST	CCL	CCAD				
		PRES	PRES	Hosp				INST																							
Caring for Patients	Potential Serious Safety Events	2	0	2	2	0	0	0	0	1	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
	CLABSI	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
	CAUTI	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
	H.A. C-diff	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
	Total Falls	29	4	21	16	1	1	1	1	3	0	4	2	5	1	0	2	2	2	1	1	1	1	0	1	1	1	1	1		
	Patient Falls (P+OP)	23	3	17	13	1	1	0	0	2	0	3	2	4	1	0	2	2	2	1	1	1	1	0	1	0	1	0	1		
	Visitor Falls	6	1	4	3	0	0	1	1	1	0	1	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	
	Caregiver Falls	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
	Clinical Codes	14	2	10	8	0	1	0	0	0	2	1	0	2	0	1	1	0	2	1	0	1	0	1	0	0	0	0	2	0	
	Non-clinical Codes	22	10	12	9	0	0	0	0	0	2	1	1	3	1	0	1	3	1	0	1	3	1	3	2	0	0	0	0	0	
	Medication Errors	20	3	17	11	0	0	0	0	0	5	2	0	6	0	1	1	1	1	1	1	1	1	0	0	0	0	0	0	0	
	Plan of Care visits					96%	87%			94%	93%			85%	89%	85%	89%	88%	82%	83%	68%	93%	90%	85%	88%	94%	89%	92%	81%		
	Other Safety Risks Concerns, Near Misses	14	6	6	3	0	0	0	0	0	2	0	0	3	0	1	0	0	0	0	4	0	1	0	1	0	1	2	0		
	Patient Exp Issues	7	2	5	3	0	0	0	0	1	1	0	2	0	0	0	0	0	0	1	0	1	0	1	0	0	0	0	0		
Caring for Caregivers	Caregiver Exp Issues	9	2	7	5	0	0	0	0	2	1	0	2	0	2	0	0	2	0	0	0	0	1	1	0	0	0	0	0		
Caring for the Organization	Adjusted Adult Occupancy %					86%	84%			86%	91%			84%	93%	84%	86%	88%	83%	90%	93%	83%	85%	89%	90%	97%	70%	90%	0%	0%	
	ICU Beds	51	8	39	33	3	4	3	2	-2	5	0	6	0	3	5	6	4	2	0	3	2	1	0	4						
	RNU Beds	-36	-53	-42	65	19	19	5	-8	3	-13	-6	-107	15	5	0	3	23	32	-12	2	-9	-66	27	32						
	BH Beds	41	21	20	20	8	1	1	-1	8																					
	Women's Beds	87	7	80	80			25					14	23				16		2	4	-4		7							
	Children's Beds	122	15	107	76			12					25	27				31		12		0	4		11						
	OR Volume	1423	402	868	558	44	95	46	28	82	89	24	340	49	46	29	18	38	83	72	15	49	183	27	96						
	ED Volume	3049	780	1905	1733	77	304	185	129	138	214	236	102	172	83	120	144	100	86	165	110	120	229	156	179						
	ED Hoos	125	69	56	41	0	6	2	6	8	5	1	15	0	5	4	2	2	0	17	2	9	41								
	LBTC Rate					0%	4.6%	1.1%	0%	5.1%	14.5%	4.2%	3.9%	18.6%	1.2%	13.3%	8.3%	5%	6%	1.8%	0%	1.6%	1.7%	1.9%	1%						
	Environmental, Safety, Other Concerns	3	0	3	2	0	0	1	0	0	0	0	0	1	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0		
	Slips Filed	16030								16030																					
		11243								11243																					
		1528		295	286					1242										225											



Enterprise Tier 6 Huddle

how are we doing *today*?

Tier Huddle	Huddle Date	Category	CCHS	FL PRES	OH PRES	Reg Hosp
Caring for Patients						
Potential Serious Safety Events			2	0	2	2
CLABSI			0	0	0	0
CAUTI			0	0	0	0
H.A. C-diff			0	0	0	0
Total Falls			29	4	21	16
Patient Falls (IP-OP)			23	3	17	13
Visitor Falls			6	1	4	3
Caregiver Falls			0	0	0	0
Clinical Codes			14	2	10	8
Non-clinical Codes			22	10	12	9
Medication Errors			20	3	17	11
Plan of Care vlets						
Other Safety Risks Concerns Near Misses			14	6	6	3
Patient Exp Issues			7	2	5	3
Caring for Caregivers						
Caregiver Exp Issues			9	2	7	5
Caring for the Organization						
Adjusted Adult Occupancy %						
ICU Beds			51	8	39	33
RIU Beds			-36	-53	-42	65
BH Beds			41	21	20	20
Women's Beds			87	7	80	80
Children's Beds			122	15	107	76
OR Volume			1423	402	888	558
ED Volume			1373	353	900	557
ED Volume			3049	780	1965	1733
ED Holds			2795	650	1810	1683
ED Holds			125	69	56	41
LBTC Rate						
Environmental, Safety, Other Concerns			3	0	3	2
Slots Filled			16030			
			11243			
Express Care Volume			1528		288	288
			1000		54	54

SUCCESSFUL HUDDLES



Start & end on time



<15 minutes



Write it down

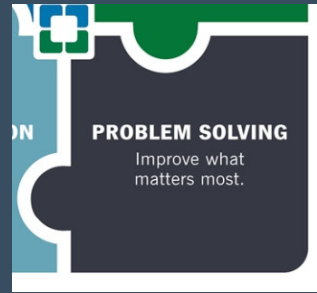


Everyone shares



Embrace/probe issues and problems

PROBLEM SOLVING



WHAT MATTERS MOST?

We can't work on **everything**

453 things to improve?

Focus on a **crucial few**
Which metrics are **most** important?

System to share, prioritize and solve problems



EASY TO IDENTIFY AN OPPORTUNITY

Date Submitted 4-8-2019
 Card Title Information Update
 Card Author Meissa
 Department CI

1. What is the problem you are trying to solve (current condition)? How large is the problem? How often is it happening?
 There are multiple spreadsheets used to capture updates on CI work (eg, A3s, ROI, Gemba visits), and there is no standard timing for updates.

2. What is the target condition (goal)?

A single source for providing updates with clear expectations on when to update.

Thank you for your idea. Check Kaizen board for updates.

Assigned Team _____

Assigned Coach _____



Date Submitted _____

Card Title _____

Card Author _____

Department _____

JDI
RC
A3

1. What is the problem you are trying to solve (current condition)? *How large is the problem? How often is it happening?*

2. What is the target condition (goal)?

Thank you for your idea. Check Kaizen board for updates.

Assigned Team _____




Assigned Coach _____

Built in Coaching

Solution not included
(many possibilities)

Pause until idea approved
& coach assigned

Problem Solving Approaches

Understanding of Problem	Problem is <u>well</u> understood Root cause & solution are <u>known</u>	Problem is <u>somewhat</u> understood Root cause & solution are <u>unknown</u>	Problem is <u>not</u> understood Root cause(s) & solution are <u>unknown</u>
Effort to Address Problem	Low	Medium	High
Name	Just Do It (JDI)	Root Cause	Complex (A3)
Visual	 Green Dot	 Yellow Dot	 Red Dot

Collaboration - Identify stakeholders impacted by the problem & involve them in the improvement work

Continuous Improvement © 2018 Cleveland Clinic Foundation, All Rights Reserved



Discharge Order to Actual Discharge

Owner: Clarke/Malchow



Background & Target: At Cleveland Clinic Martin South, in 2021 we averaged 45% of our patients being discharged from the Observation Unit within 150 minutes after the discharge order is placed. We want to increase this percentage to 70% by December 31, 2021

Visual Management

Tracking data for why Patients not discharged Began 1/14/21



Completed / In Progress / Next Steps (Task Plan)

- Collect data on average discharge time for all observation patients by unit.
- Tracking why observations patients are not discharged at 150 minutes post order via pareto analysis.
- Working on communication plan for patients to have ride readily available when discharge plan is known.
- Process Map process from Hospitalist discharge of Observation patient to actual discharge.

Barriers / Concerns / Risks

- Providers placing order to allow Case Management to work on placement and patient not actually ready for discharge.
- Physical Therapist not dedicated to Observation patients.
- 42% of Observation patients admitted to units outside of Observation Unit.
- ANM's taking full assignment leaving nobody to handle flow on the unit.
- Nurses on unit were not aware of a goal.
- Patient's don't have rides timely when ready to discharge.

Decisions / Escalations

- Need a goal set by team they would like to reach with agreement by leadership.
- Discussion with Lead Hospitalist on limiting discharge order placement prior to patient ready (only put in d/c order early for complicated discharge patients).
- Drive to have Observation patients admitted to Observation Unit if beds are available.

- On track
- Not on track

Black Text Completed
Blue Text In Progress



A3 Title: VTE & Anticoagulation		Program Sponsor: Dan Raymond, MD	Program Lead: Jenna Wise	Project Owner: varies	Revised Date: 3/16/20
BACKGROUND	<p>VTE & Anticoagulation committee has oversight on VTE improvement projects (includes charter and interdisciplinary team)</p> <p>VTEs (venous thromboembolism) are blood clots which can be acquired post-operatively (PSL12) or inpatient (clinical indicator 12)</p> <p>VTEs are identified as DVT (deep vein thrombosis) and PE (pulmonary emboli)</p> <p>Aim to reduce PSL12s thus decreasing VTE associated morbidity and mortality</p> <p>PSL12s are 88% of surgical VTEs</p> <p>Evolution for PSL12 include acute brain/spinal injury PDA, MDC 14 Pregnancies, Childbirth and Puerperium and possibly if no major surgery, if vena caval thrombosis precedes VTE diag and first major procedure</p> <p>Previous projects: Keep the Pressure On 2013 and Every Missed Dose Counts</p> <p>Prevention strategies are the same for PE and DVT. Current standard prevent</p> <p>1. Correct Risk Assessment 2. Chemical prophylaxis 3. Mechanical prophylaxis/ Intermittent Pneumatic Compression 4. Mobility</p>				<p>Program maintenance on each of the following:</p> <ul style="list-style-type: none"> • VTE Dashboard • CC-MMR (Cleveland Clinic Anticoagulation Management Program) revised and updated every 6 months • Updated VTE Risk Assessment • VTE REDCap • VTE Macros in Imaging
	CURRENT CONDITIONS			<p>Dashboard</p> <ul style="list-style-type: none"> • Provide accurate physician and nursing unit level data - discovered CT data team pulls physician taxonomy from finance tables, but should be pulling from OPSA tables. VTE dashboard to transition to OPSA table. • CORs, Thoracic, Spine, Cerebrovascular receiving reports. Will expand to include other departments in NI, OPL, HVTI in Q4. <p>Risk Assessments</p> <ul style="list-style-type: none"> • Analyze risk assessment audits for DDSDI and NI to look for trends and opportunities <p>Missed Dose Data</p> <ul style="list-style-type: none"> • Create dashboard for self-service data extraction (in draft form) • Analyze and look for trends • Finalize query for accurate analysis <p>Institute Meetings</p> <ul style="list-style-type: none"> • Meet with institute leaders, starting with CORs (8/19), NI (9/9), and HVTI (Oct) to dive into the following: <ol style="list-style-type: none"> 1. Review taxonomy and reports 2. Missed dose data 3. Review of risk assessment audits 4. Review REDCap data 5. Discuss how we can collaborate with institute on VTE efforts 	
GOALS / TARGETS	<ul style="list-style-type: none"> • 2020 Goal: PSL12 ≤ 4.5 (rate per 1000) • watch measure: Medical VTE < 17 (rate per 1000) • Provide accurate physician level and nursing unit data to permit QI efforts • Our performance from 2015-2019 is rate of 4.43 monthly average. To ensure we hit our goal we will aim for rate of 4. If we aim for rate of 4, we need 20 less PSL12 in 2020 		<p>PLAN</p>		
ANALYSIS	<ul style="list-style-type: none"> • Our PSL12 rate really has not changed since 2015. Our expected PSL12 rate goes up over time. • No strong pareto - 44% of enterprise-wide PSL12s in 2019 were attributed to DDSDI, HVTI, NI, OPL • If we can get to OIE of 1 for DDSDI, HVTI and NI we can eliminate 25 PSL12s (DDSDI OIE 1, HVTI OIE 8, NI OIE 6) • To prevent VTEs we need to do these things really well: 1. Correct Risk Assessment 2. Mechanical Prophylaxis 3. Chemical Prophylaxis 4. Mobility • VTE Risk Assessments - 100% completion. Residents audited 62 VTE Risk Assessments for appropriateness in DDSDI and NI. Results: Appropriate 52% (N=33), Over Assessed 14% (N=9), Under Assessed 33% (N=21). Do we need more reviewers auditing as these can be subjective? • Chemical prophylaxis - 75% of the time meds are given with no missed doses (enterprise 2018-2019, N=73). 78% documented compliance (NI 2012-2019, N=101) • ICCs - NI: 77% avg documented compliance (N=158, 2013-2019) and 78% observed compliance (N=14, 2020) Ent - 45% documented compliance, 34% some compliance, 21% no compliance (N=71, 2018-2019). We did not do broader observation for the enterprise. Do we need to? • Mobility - no data available. There is a mobility carepath that serves as a guide to get patients moving asap, but there is no standard for hours of mobility. The plan is not different for patients with higher VTE risk. We are not actively pursuing because nursing is doing their own project for mobility. 		<p>SUSTAIN</p>		
			<p>RECOGNITION</p>		



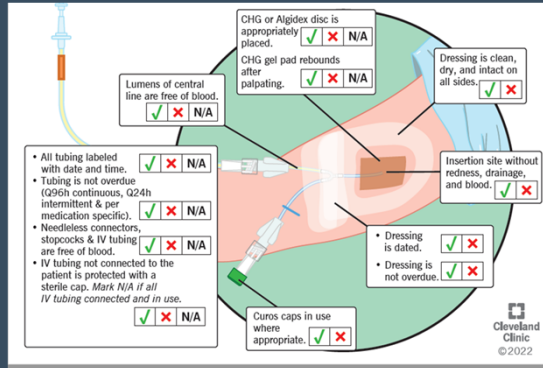
STANDARDIZATION



PROCESS CONFIRMATION



PIC of CVL



Standardization

Central Line Assessment

Please confirm that the below interventions are in place, at this exact moment in time. If an intervention is missing and is recommended, mark as an opportunity and implement the recommended intervention.

Date: _____ Assessor role: (circle one) Clinical RN, NM, ANM, CNS, IP, other: _____

Hospital: _____ Unit: _____ Bed: _____

Type of central line:

Non-tunneled central line Non-tunneled dialysis catheter/apheresis

Tunneled central line Tunneled hemodialysis catheter/apheresis

PICC Unknown

Umbilical catheter Other _____

Implanted vascular access (port)

CHG bath completed: (circle one) Yesterday / Today / No / CHG allergy / Patient declined / NA

Location of central line: (circle one) Groin / Neck / Chest / Umbilical / Arm / Translumbar / Leg / Scalp

CHG or Algidex disc is appropriately placed. ✓ ✗ N/A

CHG gel pad rebounds after palpating. ✓ ✗ N/A

Dressing is clean, dry, and intact on all sides. ✓ ✗

Lumens of central line are free of blood. ✓ ✗ N/A

All tubing labeled with date and time. ✓ ✗ N/A

Tubing is not overdue (Q96h continuous, Q24h intermittent & per medication specific). ✓ ✗ N/A

Needless connectors, stopcocks & IV tubing are free of blood. ✓ ✗ N/A

IV tubing not connected to the patient is protected with a sterile cap. Mark N/A if all IV tubing connected and in use. ✓ ✗ N/A

Insertion site without redness, drainage, and blood. ✓ ✗

Dressing is dated. ✓ ✗

Dressing is not overdue. ✓ ✗

Curocaps in use where appropriate. ✓ ✗

Cleveland Clinic © 2022

Performing a Central Line Assessment (CLA)

Always document what you see at the time of the assessment. Please complete 1 CLA per central line. For any questions, please contact your Clinical Nurse Specialist or Infection Preventionist.

Types of Central Lines

Non-Tunneled: Inserted directly into a central vein, preferably the subclavian or jugular and the catheter tip resides in the superior vena cava or right atrium and are appropriate for short term use (days or weeks).

Examples of non-tunneled lines are: PICC, CORDIS, Triple Lumen Cath, PA catheter

Tunneled: Inserted directly into a central vein and the tip resides in the superior vena cava or right atrium. Tunneled lines are passed under the skin from the venous insertion site to a separate exit site. Tunneled CVAAs can remain in place for months or years.

Examples of tunneled lines are: Broviac, Hickman, Hols

Implanted vascular access device (IVAD): Catheter attached to plastic, stainless steel, or titanium port surgically implanted under the skin.

Examples: Port, Port-a-cath, Medi-port

Classification

CHG Bathing: Review the medical record for documentation of a CHG bath in the last calendar day. If patient has a CHG allergy, soap and water is sufficient.

Tubing

Verify all IV tubing is free of blood, labeled with the last date and time of tubing change, and the duration of utilization is appropriate.

Continuous infusion: Primary administration set tubing NOT disconnected from patient's intravenous catheter or secondary administration set tubing that is NOT disconnected from the primary tubing (i.e. not disconnected at any time for any reason like leaving the floor, bathroom, procedure). Tubing changed every 96 hours.

Intermittent infusion: Primary administration set tubing disconnected from the patient's intravenous catheter or secondary administration set tubing that is disconnected from the primary administration set tubing. Tubing changed every 24 hours.

Lumens of the central line & tubing should be clear of any visible residual blood.

If any evidence of blood is visible in IV tubing, change the tubing.

If residual blood is visible in lumens of central line, flush the central line to clear the blood.

Central line dressing

Verify the following are in place. If the dressing and/or insertion site does not meet the below criteria, perform a dressing change.

The dressing is clean and dry.

All 4 sides of the dressing adhere to the patient's skin.

There is no more than a dime size of drainage at the insertion site.

The insertion site is without signs of infection (redness, warmth, drainage).

The CHG pad rebounds upon palpation (without unrolling the dressing, gently press on the pad to assess if it rebounds). If an imprint remains on the pad, change the dressing.

The CHG gel pad/patch or Algidex disc is placed over insertion site. If a Biopatch is in use, verify the colored side is facing up.

The transparent dressing has been changed within the last 7 days. If gauze dressing being used, verify it has been changed within the last 2 days. This is verified by observing the date noted on the dressing. If it is not labeled, confirm the last dressing change date documented in Epic and label the dressing.

Cleveland Clinic © 2022

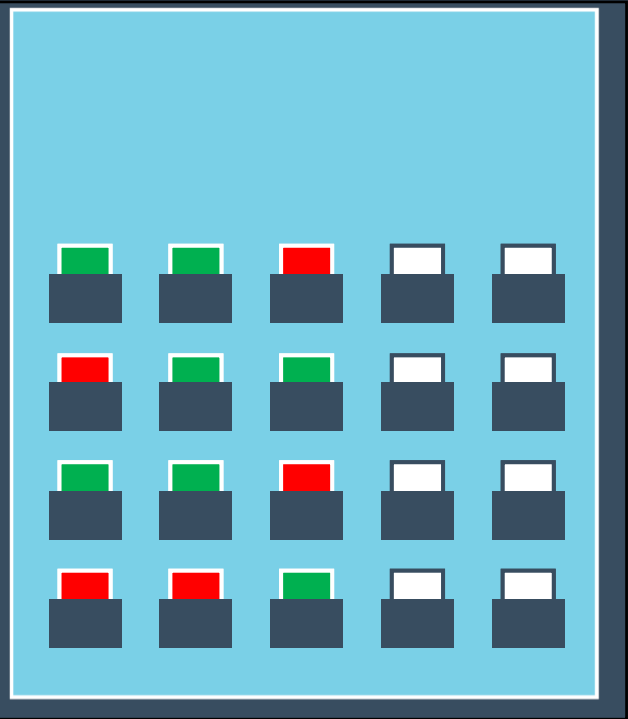


PROCESS CONFIRMATION

Start with a well understood, tested, and documented process.

Develop a short assessment that confirms if the process is being sustained.

Use a bold visual tracker to communicate the assessment plan and the results.

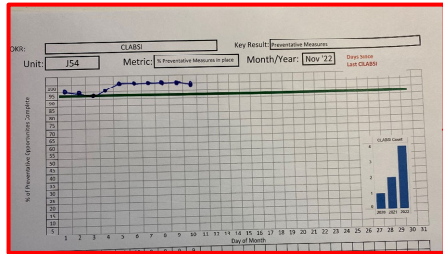


Process Confirmation **CLABSI** Date **2-9-23** Cleveland Clinic

CHG Bath: Done vs. Not Done

CHG Bath ID	Status
G81-01	NOT TO BE DONE
G81-02	NOT TO BE DONE
G81-03	NOT TO BE DONE
G81-04	NOT TO BE DONE
G81-05	NOT TO BE DONE
G81-06	NOT TO BE DONE
G81-07	NOT TO BE DONE
G81-08	CHG Bath: <input checked="" type="checkbox"/>
G81-09	CHG Bath: <input checked="" type="checkbox"/>
G81-10	CHG Bath: <input checked="" type="checkbox"/>
G81-11	NOT TO BE DONE
G81-12	NOT TO BE DONE
G81-13	CHG Bath: <input checked="" type="checkbox"/>
G81-14	NOT TO BE DONE
G81-15	NOT TO BE DONE
G81-16	NOT TO BE DONE
G81-17	NOT TO BE DONE
G81-18	NOT TO BE DONE
G81-19	NOT TO BE DONE
G81-20	NOT TO BE DONE
G81-21	NOT TO BE DONE
G81-22	NOT TO BE DONE
G81-23	NOT TO BE DONE
G81-24	CHG Bath: <input checked="" type="checkbox"/>
G81-25	NOT TO BE DONE
G81-26	NOT TO BE DONE
G81-27	NOT TO BE DONE
G81-28	NOT TO BE DONE
G81-29	CHG Bath: <input checked="" type="checkbox"/>
G81-30	NOT TO BE DONE
G81-31	NOT TO BE DONE
G81-32	NOT TO BE DONE
G81-33	NOT TO BE DONE
G81-34	NOT TO BE DONE
G81-35	NOT TO BE DONE
G81-36	NOT TO BE DONE

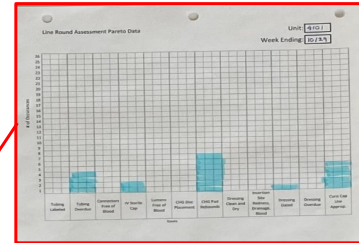
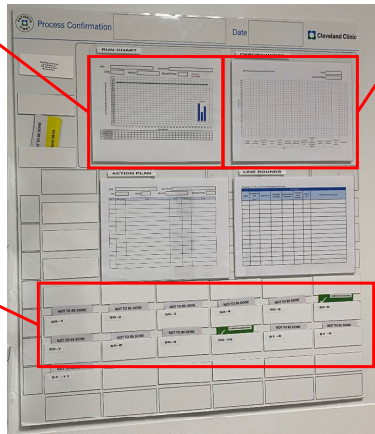
CLABSI Process Confirmation Board



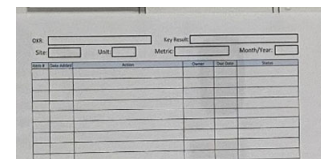
Run Chart of Performance



Cards Indicating What to Check and Results of Assessment



Pareto of Failure Modes

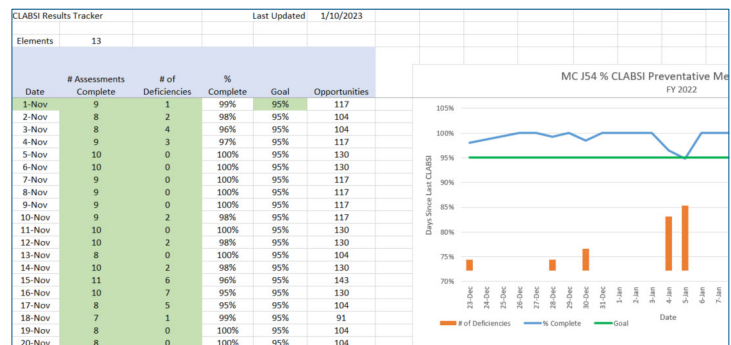


3 W Action Plan

Tracking and Reporting

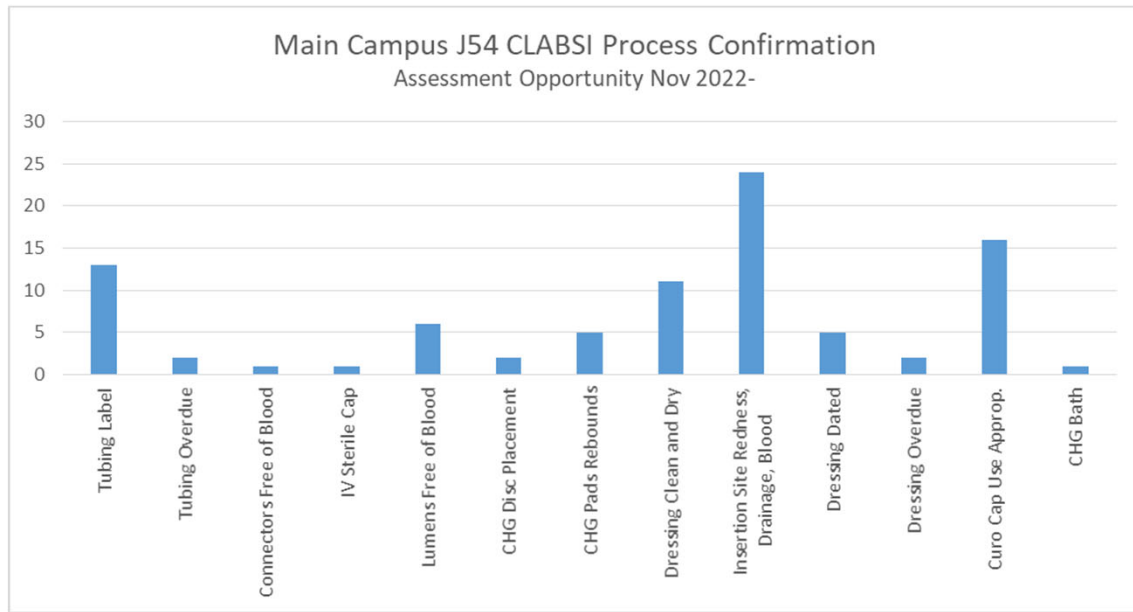
A standardized spreadsheet was created for each unit to track the following:

- # Assessments Completed
- # of Deficiencies (Failure Modes)
- % of Preventative Measures in Place (Run Chart)
- Failure Mode by Cause (Pareto)
- Blank Forms/Cards
- Card Template
- Standard Work



The tracking tool was designed for minimal data entry. Leaders only need to enter 2 numbers each day and Pareto data monthly.

Board Elements: Pareto



So how does this all come together?

- What matters most → CLABSI
- How are we performing →
- What's getting in the way →
- Standardization / PC

Tier 1- nurses to NM (unit level)	Tier 2- NM to ND (service line)	Tier 3- ND to CNO	Tier 4- CNO to hospital	Tier 5- hospital to ACNO	Tier 6- ACNO to ET
Days since last CLABSI on unit	Days since on unit	Days since on service line	Days since CLABSI in hospital	Days since CLABSI in hospital	Days since CLABSI in Enterprise
# patients with central lines	# patients w/ central lines	# patients w/ central lines	# patients with central lines		
Room numbers- central lines					
# Assessments previous day	# Assessments previous day	# Assessments previous day			
% CLAs completed	% CLAs completed	units with % CLAs completed <95%			
High Reliability: # CLA perfect from previous day	# CLA perfect from previous day	# CLA perfect from previous day	% CLAs perfect in hospital	% CLAs perfect in hospital	Hospitals with CLA % perfect, less than 95%
details regarding fall outs from previous day (elements of CLA)	details regarding fall outs from previous day	details regarding fall outs from previous day			

So how do we sustain and grow new leaders in this system?

- Onboarding
- Step into existing systems
- Highlight examples of who's doing it well
- Leader rounding
- 1 on 1 Coaching
- CI Model and CI is part of formal nursing leadership development program (nurse manager basics, residency and fellowship), Shared governance council
- SoIVE

What if leaders don't/won't/can't?

- Start with WHY: team engagement and improved outcomes
 - “It's not just a bath!” “Look at the outcomes”
- Support the caregiver: Identify and address barriers
- Clarity - this is performance expectation and part of annual performance review
- Part of our OKRs

TEAM DISCUSSION



What did you **learn**?



What will you **use** in your work?



What will you share with your team or leaders, and how will it **benefit** your team or patients (customers)?

Key Takeaways

- Reflections from a health care executive on improving patient care
 - Easy to determine what matters most
 - More difficult to ensure entire TEAM knows what matters most – and how to improve it!
 - How do you know if you are getting there?



Every life deserves world class care.

