Welcome

OPQC NEO ACTION PERIOD CALL

September 4, 2013
2:00-3:00pm
Please don’t put us on HOLD

• To avoid the technical difficulties we encountered from background noise on the May call, today all participants will be muted until the lines are opened for questions, and discussion.

• Then, if you need to step away
  – Use the MUTE button on your phone or
  – You can use *6 to place the call on MUTE and *6 to come off of MUTE
# Agenda

<table>
<thead>
<tr>
<th>Time</th>
<th>Topic</th>
<th>Presenter</th>
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<tbody>
<tr>
<td>2:00 pm</td>
<td>Welcome</td>
<td>Pat Heinrich</td>
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<tr>
<td>2:05 pm</td>
<td>How are we doing – data review</td>
<td>Dr. Laurel Bookman</td>
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<td>2:10 pm</td>
<td>Infection</td>
<td>Dr. Michele Walsh</td>
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<td>• Blood Culture Bundle</td>
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<td>• Line Maintenance</td>
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<td>• Data breakdown</td>
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<td>• Line maintenance teams</td>
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<td>article</td>
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<tr>
<td>2:40 pm</td>
<td>OB Partnership HM Team Sharing</td>
<td>All</td>
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<tr>
<td>2:55 pm</td>
<td>Next Steps</td>
<td>Pat Heinrich</td>
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INFECTION DATA
Number of infections per Month

Mean Infections Feb 2009-Dec 2009 (184/11) = 17
% of line insertion bundles for which all components were implemented

- Oct-Dec 2011: 98%
- Jan-Mar 2012: 92%
- Apr-Jun 2012: 95%
- Jul-Sep 2012: 90%
- Oct-Dec 2013: 97%
- Jan-Mar 2014: 99%
- Apr-Jun 2014: 98%
- Jul-Sep 2014: 96%
- Oct-Dec 2015: 94%
% of observations of maintenance bundles for which all components were completed
Infants 22-29 Weeks Discharged with at Least One Nosocomial Infection at Your Hospital
Collaborative Aggregate

01/01/09 Centerline 12.3%
12/01/11 Centerline 10.8%

Two year baseline was used for centerline and control limits
HUMAN MILK DATA
% of Infants whose mothers first pumping was within 6 hours of giving birth

median

OPQC
Ohio Perinatal Quality Collaborative
% of Infants fed any human milk within the first 72 hours of life

Goal
Median
% of infants fed >= 100 ml/Kg/day of human milk by 21 days of life

No change here
Team Sharing

REDUCING VARIATION IN PRACTICE
Audience Poll

What changes have you made since last month's AP call focused on reducing variation in how a positive culture for CONS is determined to be a true infection?

A. We reviewed the definitions of Bacterial Pathogen and Skin Contaminant (for OPQC and VON) in the revised table with our staff
B. We changed the way we draw cultures
C. We changed the way we identify an infection or a contaminant
D. We invited our Infection Control staff to join our NICU team
E. Other – please type what you did in the chat box and we will share with all teams
HOW CAN YOUR DATA HELP YOU FOCUS YOUR EFFORTS TO REDUCE INFECTION?
Maint Bundle - Reason for fail
Aggregate - Oct '12 - Jan '13

Graph Represents:
88 MB Observations
104 failures
Audience Poll

Where do you think your team needs the most improvement effort focused (choose as many as desired)

A. Daily assessment of need
B. Daily assessment of dressing
C. Prefilled flush
D. Close system maintained
If your unit is experiencing infections, attempt to **focus improvement efforts** on identified “Reasons for Fail”
OPQC Infection Data from 12/01/2011 to 06/30/2013

The Blue Diamond is your hospital.

ON INDIVIDUAL TEAM GRAPHS
THE BLUE DIAMOND IS YOUR HOSPITAL
Will show name and identify Aultman if we get permission prior to call if not will ID only as high performer.
Remember The Tools

- Problem solving to identify the root causes of the problem that caused the events
- Using the right tools can help diagnosis/identify the cause of a problem
- Tools
  - 5-Why
  - Cause and Effect
  - Sequence-of-Events
  - FMEA (failure modes and effects analysis)

Also known as **RCA**

**SWOT**

- Strengths
- Weaknesses
- Opportunities
- Threats
Do you have a “Team”? 

ARTICLE: Utilizing a line maintenance team to reduce central-line-associated bloodstream infections in a neonatal intensive care unit.

Holzmann-Pazgal G, Kubanda A, Davis K, Khan AM, Brumley K, Denson SE.

OBJECTIVE:
To determine the association of a central-line maintenance team on the incidence of central-line-associated bloodstream infections (CLABSIs) in the neonatal intensive care unit (NICU).

STUDY DESIGN:
Central line maintenance in the NICU was limited to a line team starting in March 2008. CLABSI rates were determined before (December 2006 to February 2008) and after implementation of the line team (March 2008 to August 2010) utilizing consistent National Healthcare Safety Network definitions. Rates were calculated by birth weight categories and overall. Data analysis was performed by two-proportion t test using Minitab.

RESULT:
Overall CLABSI decreased by 65% after implementation of the line team. Pre intervention, mean overall CLABSI rate was 11.6/1000, as compared with 4.0/1000 after intervention (P<0.001). Birth-weight-specific CLABSI rates also decreased significantly. Decreased infection rates were sustained over time.

CONCLUSION:
A line team provided for standardized, consistent central-line maintenance care leading to a significant, sustained decrease in CLABSI in a NICU

Team Sharing
OB/Neo Partnerships on HM

• What’s happening at your site? Tell us about partnering with your OB team (OBs and Nurses)
  – Tests of change
  – Challenges, Successes, Lessons Learned
  – Next Steps
Next Steps

• October **Action Period Call** is October 2\textsuperscript{nd} @ 2:00 pm ET

• September **Monthly Data** is due October 7\textsuperscript{th}

• **MRP** is due September 11\textsuperscript{th}
  