

HQIC Patient Safety: Sepsis

Welcome!

- All lines are muted, so please ask your questions in Q&A.
- Please actively participate in polling questions that pop up on the lower right-hand side of your screen.
- Please be aware that this event will be recorded.

We will get started shortly!

HQIC Sepsis



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Amy Ward, MS, BSN, RN, CIC

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 **ALLIANT**
HEALTH SOLUTIONS

HQIC
Hospital Quality Improvement Contractors
CENTERS FOR MEDICARE & MEDICAID SERVICES
EQUALITY IMPROVEMENT & INNOVATION GROUP

Making Health Care Better *Together*

COLLABORATORS:

Alabama Hospital Association
Alliant Health Solutions
Comagine Health
Georgia Hospital Association
KFMC Health Improvement Partners
Konza

Hospital Quality Improvement

Welcome from all of us!



HAI Reduction Co-Leads



Amy Ward, MS, BSN, RN, CIC **INFECTION PREVENTION SPECIALIST**

Amy is a registered nurse with a diverse background in acute care nursing, microbiology, epidemiology and infection control. She is passionate about leading and mentoring new and future infection preventionists in their career paths.

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Rhonda Bowen, BSHS, CIC, CPPS, CPHQ, CPHRM **SENIOR IMPROVEMENT ADVISOR, PATIENT SAFETY**

Rhonda has worked in rural and critical access hospitals for over 30 years and directed patient safety, quality and infection prevention and control for the past 14 years. She is passionate about all aspects of patient safety, infection prevention and control, especially the effects of health literacy and organizational safety culture on patient outcomes.

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Learning Objectives

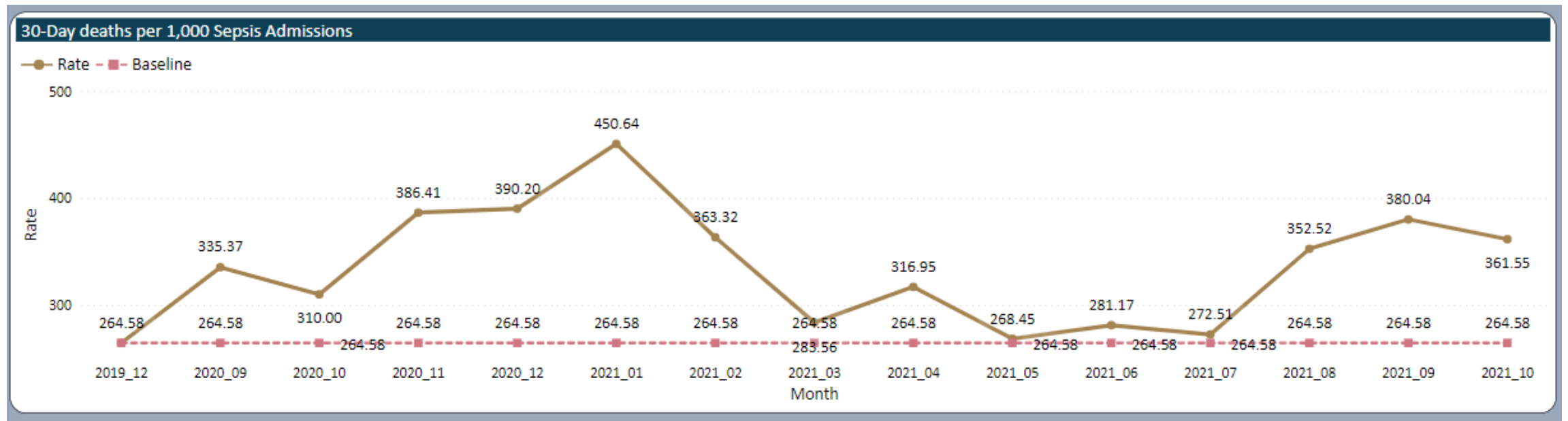
- Sepsis round-up
- Moving towards improvement
 - Human factors and systems review
- Health equity related to sepsis

Sepsis: The Big Deal Reminder!

- Hospitalizations and deaths
 - 1.1 million cases of sepsis annually in Medicare patients in the United States
 - 270,000 deaths every year
 - One in three patients who die in a hospital is diagnosed with sepsis
 - Mortality within six months of sepsis diagnosis and discharge: About 60% for septic shock and 36% for severe sepsis among inpatient Medicare patients
- Inpatient and skilled nursing facility (SNF) estimated at \$41.5 billion
- 18-26% of sepsis patients are readmitted
- Under recognized
- Progresses quickly

Sepsis Measures Reminder: Mortality

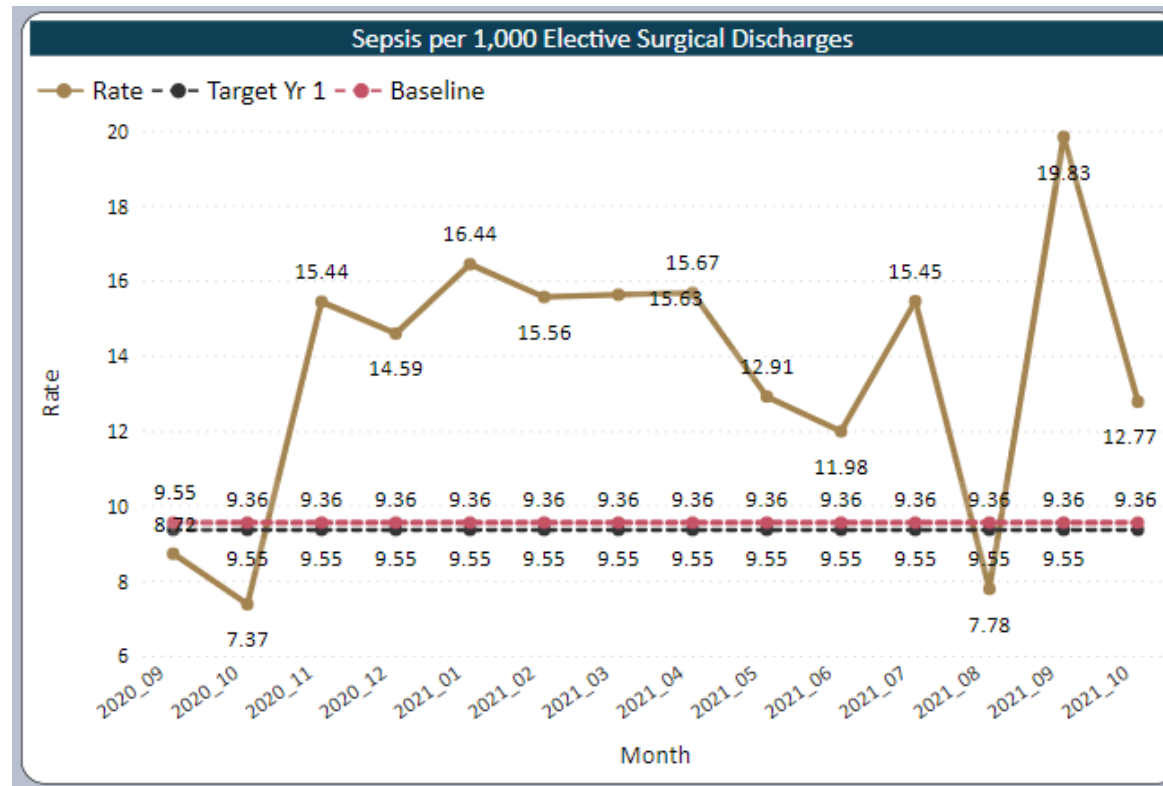
- Numerator: Number of Medicare patients who died within 30 days of being diagnosed with sepsis.
- Denominator: Number of Medicare patients who were admitted with a primary or secondary diagnosis of sepsis, including sepsis present on admission.



4298/12,536- worsening

Sepsis Measures Reminder: Sepsis Shock

- Numerator: Post-operative sepsis cases, secondary diagnosis.
- Denominator: Elective surgical discharges of persons over age of 18.



164/12,269 - improving



**SEPSIS
IS A MEDICAL
EMERGENCY**

ANY INFECTION CAN LEAD TO SEPSIS

Person-Centered Care



*Every **system** is perfectly designed to achieve exactly the results it gets. **Don Berwick, MD***

President Emeritus and Senior Fellow, Institute for Healthcare Improvement, former Administrator of the Centers for Medicare & Medicaid Services



Human Factors: 30k Foot View

A “big picture” way to view human factors is to think about:

- The individual
- The job
- The organization
- The design of the environment, equipment and systems and how they impact an individual’s health and safety-related behavior



World Health Organization,
https://www.who.int/patientsafety/research/methods_measures/human_factors/human_factors_review.pdf

Human Factors: The Details

- Human factors mean understanding how people interact with the products, processes and systems in their work environments
- Human beings have limited attention spans
 - We perform worse when we are tired
 - We are impacted by stress
 - We can only focus on one thing at a time
 - We forget things
 - When systems ask us to go beyond these and other limits, failures can occur

Why Should We Care About Human Factors?

- We're all human - we make mistakes
- Human behavior has a natural tendency to drift
- Nearly all accidents are a result of human error
- Healthcare systems strive for error reduction in patient care
- Identification of human causes of errors and interventions to prevent errors can result in error reduction
- When we put safety entirely in the hands of human behavior instead of system design, we leave ourselves open to risk

Focus on Systems

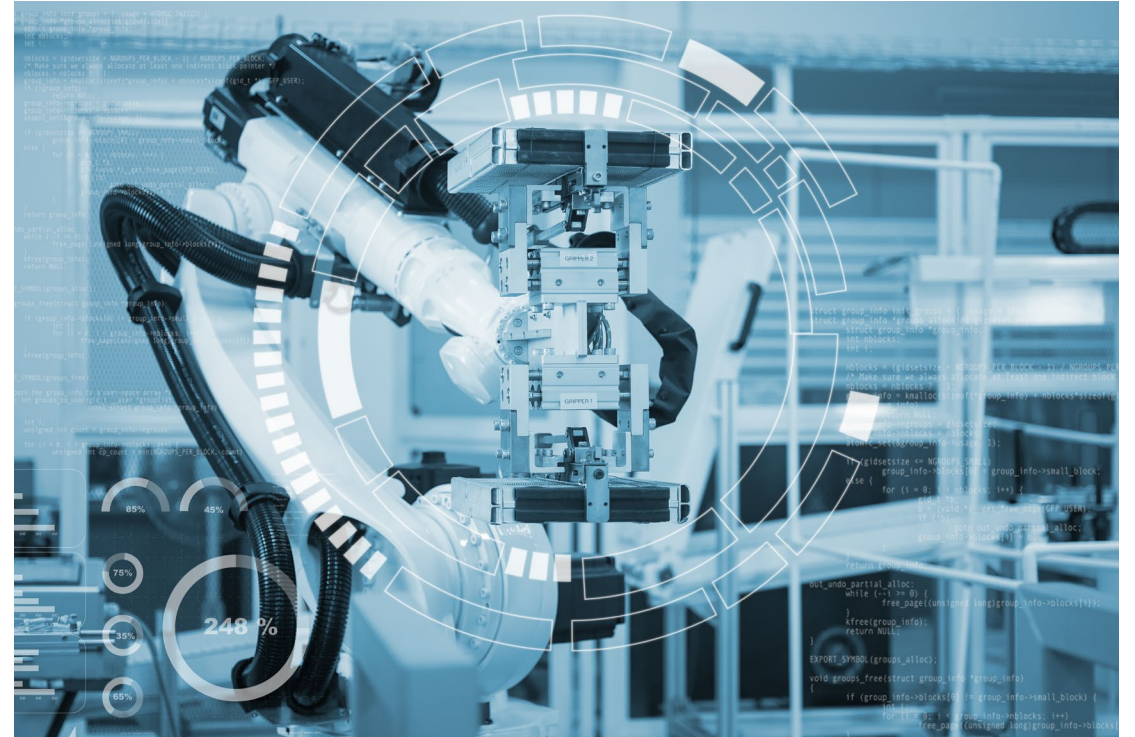
- Systems are
 - The environment in which organizational processes are performed
 - The combination and relationship among:
 - Tasks and processes
 - The people involved
 - Organizational culture
 - Environmental factors
 - Tools and technology
 - Equipment and resources available
- Systems drive organizational outcomes

Process Design

- Use segmentation in process design. One standard way might not work for every instance—same principals, but not same processes. Example, specific therapy for each type of cancer, not one for all cancer.
- Try new design on the willing and the best. If you can't get it right with this group, what makes you think you can get it right with others?
- Different segments, slightly different design—evening, night shift, etc.

Design (continued)

- Too often, systems are designed in a way that do not account for how people interact with their work environment.
- Poorly designed medical devices, uncoordinated care processes and fragmented systems lead to error.

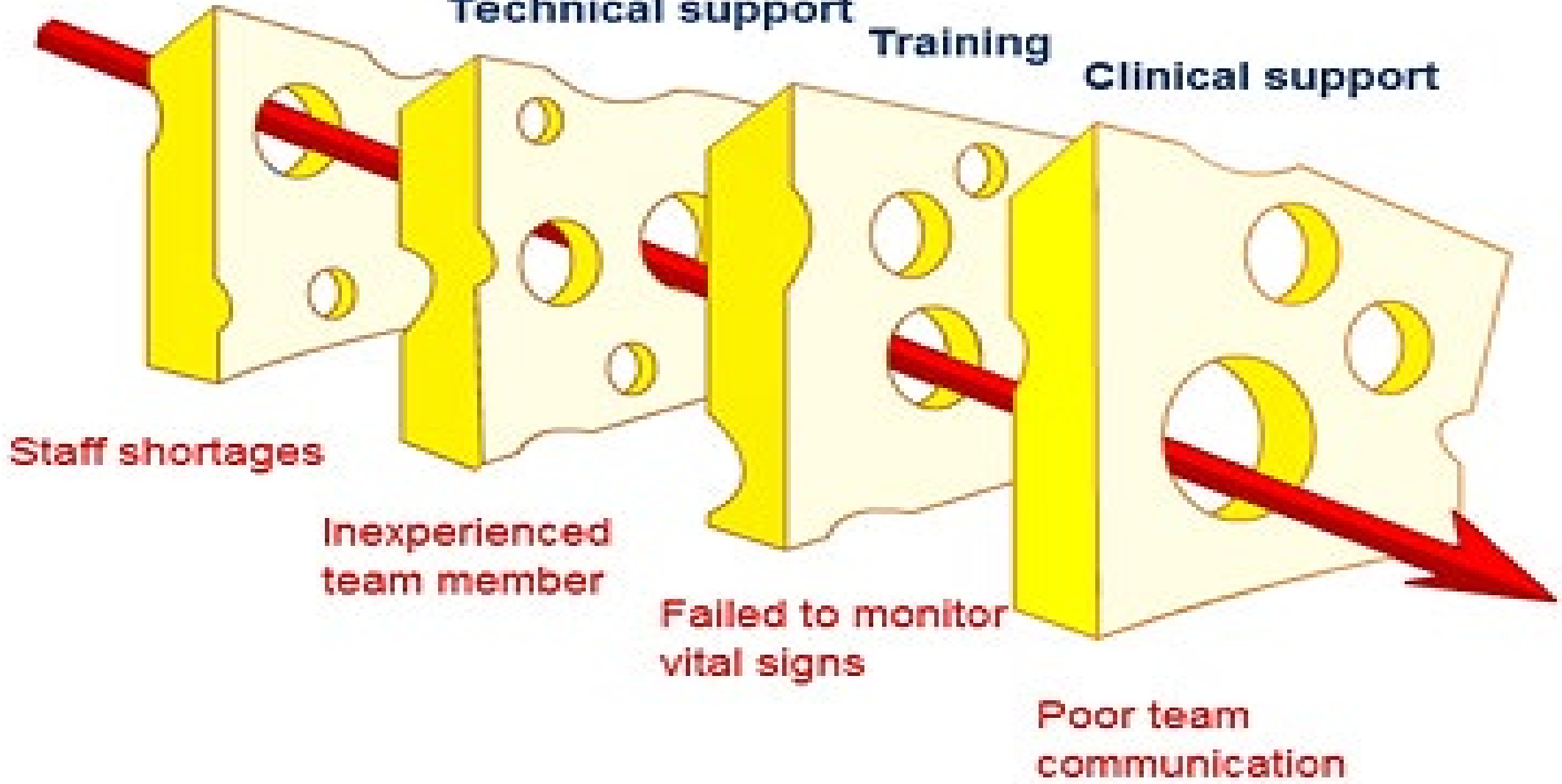


Culture & leadership

Technical support

Training

Clinical support



Staff shortages

**Inexperienced
team member**

**Failed to monitor
vital signs**

**Poor team
communication**

Where Can We Have the Greatest Impact?

- How do you know about failures in design/policy/process?
- Walk around and ask as a dyad - leader and frontline staff!
- Staff should be able to answer five questions about a process:
 - How do they do it
 - With what do they do it with
 - When do they do it
 - Who do they do it with
 - Where do they do it

Where Can We Have the Greatest Impact?



Recognize that staff are our greatest asset



Design systems to fit human capabilities and limitations, so systems are safe and reliable

Capturing how work is really done



Treat well-being of your team as a systems issue

Health Equity and Race/Ethnicity

- Black and other non-white individuals have nearly twice the incidence of sepsis as white individuals.
- Sepsis mortality in black individuals is nearly twice that of the white population.
- Sepsis mortality among American Indians/Alaskan Natives and Hispanics are 1.14 to 1.24 times higher than white population.
- Black and Native American patients are more likely to be readmitted following a sepsis hospitalization as compared to their white counterparts (1.29 times the risk for Blacks and 2.39 times the risk for Native Americans).

[Sepsis Alliance Health Equity Fact Sheet](#)

Health Equity and Poverty

- Adults below the poverty line have over three to four times the risk of dying of sepsis compared to adults whose family income is at least five times the poverty line.
- Adult patients without health insurance are more likely to die of sepsis than privately insured patients. In addition, they are less than half as likely to be discharged to a nonhospital healthcare facility or discharged with home healthcare.

Organizational Culture

- How “we do things here.”
- Your organizations’ leadership sets the stage.
- Follow policies and procedures, speak up when processes don’t work.
- Safety culture impacts adherence to processes and staff’s ability to speak up.
- How is your staff’s buy-in and acting on assessments, bundles, and alerts?
- 95% of harm is systems/process issues requiring system solutions.
- The most effective solutions involve automation or forcing functions.

Health Literacy

- Health literacy is about communication and understanding.
- Literacy is one of the strongest predictors of health status.
- You can't measure health literacy by years in school.
- Community and hospital demographics of elderly and low-income patients may significantly impact health literacy.
- Use plain language and teach-back.

Key Takeaways

- Sepsis is an emergency
 - Requires early recognition and treatment
- Organizational culture affects implementation and adherence to your order sets, bundles
- System design affects processes
- Human factors impact the interaction with the system design
- Health literacy affects patient's ability to understand
- Health equity impacts sepsis and outcomes

Let's Hear From You!

- Questions/Comments?
- Any surprises?
- What have you seen in your settings?
- Where could you use additional information or support?

- Please chat!



Resources


- [AHRQ PSI 13 Postoperative Sepsis Rate.pdf](#)
- [Hospital Toolkit for Adult Sepsis Surveillance - CDC](#)
- [Sepsis Early Recognition and Treatment Tool](#)
- [Alliant Hospital Quality Improvement Website](#)
- [Alliant HQIC Sepsis Coaching Package](#)
- [Alliant Sepsis Gap Assessment Tool](#)
- [Alliant Infection Prevention Tools](#)
- [Alliant Postop Sepsis Process Discovery Tool](#)
- [Alliant Sepsis Process Discovery Tool](#)
- [Sepsis Alliance Health Equity Fact Sheet](#)
- [For Patients and Families: Sepsis-Spot-the-Signs-Magnet](#)

Questions?



Email us at HospitalQuality@allianthealth.org or call us at 678-527-3681.

HQIC Goals



Behavioral Health Outcomes & Opioid Misuse

- ✓ Promote opioid best practices
- ✓ Decrease high dose opioid prescribing and opioid adverse events in all settings
- ✓ Increase access to behavioral health services



Patient Safety

- ✓ Reduce risky medication combinations
- ✓ Reduce adverse drug events
- ✓ Reduce *C. diff* in all settings



Quality of Care Transitions

- ✓ Convene community coalitions
- ✓ Identify and promote optical care for super utilizers
- ✓ Reduce community-based adverse drug events

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**Thank you for joining us!
How did we do today?**

Alliant Health Solutions



AlliantQIO



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