Leadership Strategy Analysis

Group 3

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Leadership Strategy Analysis

 Our organization has committed itself to continual improvement at all levels. A focus on quality improvement is maintained to provide patients with the best care possible. “Quality improvement refers to an ongoing process of innovation, prevention of error, and staff development” (Yoder-Wise, 2015, p. 362). Quality improvement exists in order to improve outcomes and improve patient safety. It has been recognized that “leadership must acknowledge safety challenges and allocate resources at the patient care and unit levels to identify and reduce risks” (Yoder-Wise, 2015, p. 362).

**Clinical Activity**

 Hospital acquired infections are an important consideration for a few different reasons. Infections increase cost and length of hospitalization. “It has been estimated that the excess cost per case for nosocomial urinary tract infections ranges from $1,200 to more than $2,700, costing the healthcare system more than $400 million annually” (The Joint Commission, 2011, p. 2).

 Infections are expensive to treat and they also may affect the reimbursement that a hospital receives. “The 2010 Patient Protection and Affordable Care act established the Hospital Acquired Conditions (HAC) Reduction Program” (Press Ganey, 2015, para 1). Hospitals receive a HAC score which is compared with other hospitals. Factors that are accounted for in the HAC score include hospital acquired infections and patient safety for selected indicators (Press Ganey, 2015, para 3). “For those hospitals who fall into the bottom quartile, the Centers for Medicare and Medicaid Services (CMS) can withhold 1% of their reimbursement” (Press Ganey, 2015, para 1).

**Collaborative Team**

A collaborative interdisciplinary team has been assembled to address the issue of catheter-associated urinary tract infections (CAUTIs). The team consists of 2 staff nurses, 2 nursing assistants, a representative from the infection control department, and a hospitalist physician. The team members have all been chosen based on the unique knowledge and skills that they possess.

 The nurses have been chosen because they are direct care providers. They are charged with delegation and supervision to the nursing assistants who are charged with attending to a large portion of patients’ hygiene needs. The nursing assistants are an important part of the team because they are “in the trenches”. They do much of the direct care and can provide insight into what challenges may be occurring. They can also provide insight into what interventions may be helpful. The infection control representative is an integral team member because he or she can provide expert information on infection control practices. A hospitalist physician has been chosen because the physician is essentially the lead of the patient care team. The physician is responsible for providing the orders for patient care and should be included in infection prevention measures.

**Data Collection Method**

 The collaborative team has chosen to begin the quality improvement process by gathering information about the problem with CAUTIs using a fishbone diagram. Please see appendix for visual depiction of this activity. “The fishbone diagram is an effective method of summarizing a brainstorming session” (Yoder-Wise, 2015, p. 369). This method of data collection was chosen because it provided the different skill levels of the team a format to collaborate and work together.

 The areas of focus for the diagram included equipment-related, environment-related, caregiver-related, and patient-related causes. Potential equipment-related causes of CAUTIs included: catheters are not standardized, equipment susceptibility to bacteria, and drainage bag malfunction (reflux). Possible environmental causes that were identified include a cluttered environment, an unclean environment, and the presence of bacteria in the environment. Several caregiver-related and patient-related causes were also identified. Possible caregiver-related causes included: catheter use not indicated, improper hand hygiene, poor technique with insertion and catheter care, and improper technique for obtaining samples. Finally, the potential patient-related causes identified were female anatomy, non-compliance, incontinence of stool, and poor personal hygiene.

**Goal/Outcome**

“With an estimated 2 million patients each year acquiring infections while hospitalized, reducing health care associated infections is a patient safety issue that should be addressed by all hospitals” (Buchmann & Stinnett, 2011). In relation to this objective, our goal is to reduce catheter acquired urinary tract infections from 10% to less than 5% annually in the intensive care unit. Catheter acquired urinary tract infections are something that can be prevented with proper assessment and care.

**Strategies to Implement Change**

The team recognizes that when making a change in policy, staff needs time to adapt and accept the new change. A plan is put in place to introduce the idea to staff, educate, and then some room will be left for questions and possible improvements to the new policy. Having a team that includes staff that are directly affected by the new policy is essential since those staff members will also be directly involved with the implementation of the policy. Having staff on the team will also create more facilitators. “ If more forces favor change- facilitators- then change will be more likely to occur”(Yoder-Wise, 2015 p.307-308). A theory that will guide this change for decreasing catheter acquired urinary tract infections was created in 1973 by R.G. Havelock. This theory is called the *Six Phases of Planned Change*. The six phases are: 1) Building a relationship, 2) Diagnosing the problem, 3) Acquiring relevant resources, 4) Choosing the solution, 5) Gaining acceptance, and 6) Stabilizing the innovation and generating self renewal (Yoder-Wise, 2015 p.310). Through these six phases the staff would become familiar with the need for change, learn about the evidence-based practice behind the implementations, have a say in the new policy, and feel comfortable when it came time for the change to occur.

**Evaluation**

The QI team will be meeting quarterly in order to review data and to determine if CAUTIs have increased, decreased, or stayed the same. This review will provide the QI team with the information to determine if the interventions they have implemented have been effective. “If an outcome is not met, revisions in the implementation plan are needed” (Yoder-Wise, 2015, p. 374).

 If the team has been unsuccessful in meeting the goal of reducing CAUTIs from 10% to less than 5%, the team will investigate potential roadblocks and reevaluate the interventions and plan. When reevaluating, the team will consider assessing baseline policies and procedures, prevention strategies, and measurements (CDC, 2015). The team will continue to reevaluate quarterly to review data and to determine if the plan in place is effective or if modifications need to be put in place.

**Conclusion**

To review, the quality improvement process began by identifying the need for a reduction in catheter-associated urinary tract infections. An interdisciplinary collaborative team was assembled to form a QI team. The team collected data and formulated a plan for improvement. Measurable outcomes were established and the team established a plan to meet quarterly to evaluate progress and make changes if necessary.

Reducing the amount of catheter-acquired urinary tract infections is only one small example of quality improvement. Nurses have a responsibility to be actively involved with quality improvement activities in all areas to “improve the quality and safety of healthcare systems within which they work, and they must focus on the six competencies identified by Quality and Safety Education for Nurses (QSEN): patient-centered care, teamwork and collaboration, evidence-based practice, quality improvement, safety, and informatics” (Yoder-Wise, 2015, p. 362).

References

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Appendix

