2011 Military Health System Conference

Ventilator Associated Pneumonia: Targeting Zero

The Quadruple Aim: Working Together, Achieving Success

Stephen M. Yamada MS, CIC

January 25, 2011

Tripler Army Medical Center
Honolulu, Hawaii

Report Documentation Page

Form Approved
OMB No. 0704-0188

1. REPORT DATE	2. REPORT TYPE	3. DATES COVERED
25 JAN 2011		**00-00-2011 to 00-00-2011**

4. TITLE AND SUBTITLE	5a. CONTRACT NUMBER
Ventilator Associated Pneumonia: Targeting Zero	5b. GRANT NUMBER
	5c. PROGRAM ELEMENT NUMBER
6. AUTHOR(S)	5d. PROJECT NUMBER
	5e. TASK NUMBER
	5f. WORK UNIT NUMBER
7. PERFORMING ORGANIZATION NAME(S) AND ADDRESS(ES) **Tripler Army Medical Center,Honolulu,HI,96859**	8. PERFORMING ORGANIZATION REPORT NUMBER
9. SPONSORING/MONITORING AGENCY NAME(S) AND ADDRESS(ES)	10. SPONSOR/MONITOR'S ACRONYM(S)
	11. SPONSOR/MONITOR'S REPORT NUMBER(S)

12. DISTRIBUTION/AVAILABILITY STATEMENT
Approved for public release; distribution unlimited

13. SUPPLEMENTARY NOTES
presented at the 2011 Military Health System Conference, January 24-27, National Harbor, Maryland

14. ABSTRACT

15. SUBJECT TERMS

16. SECURITY CLASSIFICATION OF:			17. LIMITATION OF ABSTRACT	18. NUMBER OF PAGES	19a. NAME OF RESPONSIBLE PERSON
a. REPORT **unclassified**	b. ABSTRACT **unclassified**	c. THIS PAGE **unclassified**	**Same as Report (SAR)**	**11**	

Tripler Army Medical Center

-239 bed Tertiary Care facility

*264,000 local active duty, retiree, family members, VAB

*171,000 referral population

Adult Intensive Care Unit

-15 bed medical/surgical ICU

-Average census: 11.5 beds/day

- Average LOS: 3.1 days

-Average ventilator days/month: 116

Technical Work

- Addresses problems for which the definition is clear, the potential solutions are reasonably clear and usually require little or minimal learning

  – Institute for Healthcare Improvement bundle
  – Silver coated endotracheal tube
  – Reinforced the ABC weaning protocol
  – New closed suctioning system

Adaptive Work

- Addresses problems that require a change in attitudes, beliefs, and behavior
- Involves shared responsibility for change: leaders share responsibility with organizational staff and key stakeholders
- Most common error
  - Treating an adaptive problem as technical

Comprehensive Unit-Based Safety Program (CUSP)

Improve safety culture & learn from mistakes
by integrating safety practices

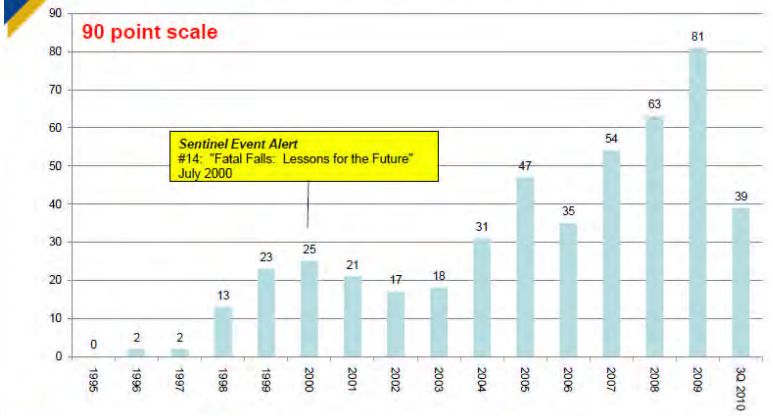
How can we improve

"Every system is perfectly designed to achieve the results it gets"

Sentinel Event Data

Fall-related Events Reviewed by The Joint Commission

(Resulting in death or permanent loss of function)



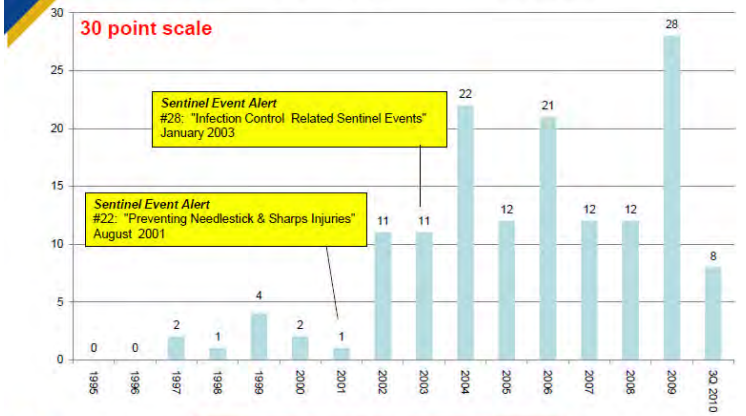
The Joint Commission

The reporting of most sentinel events to The Joint Commission is voluntary and represents only a small proportion of actual events. Therefore, these data are not an epidemiologic data set and no conclusions should be drawn about the actual relative frequency of events or trends in events over time.

Office of Quality Monitoring - 11

Infection-related Events Reviewed by The Joint Commission

(Resulting in death or permanent loss of function)



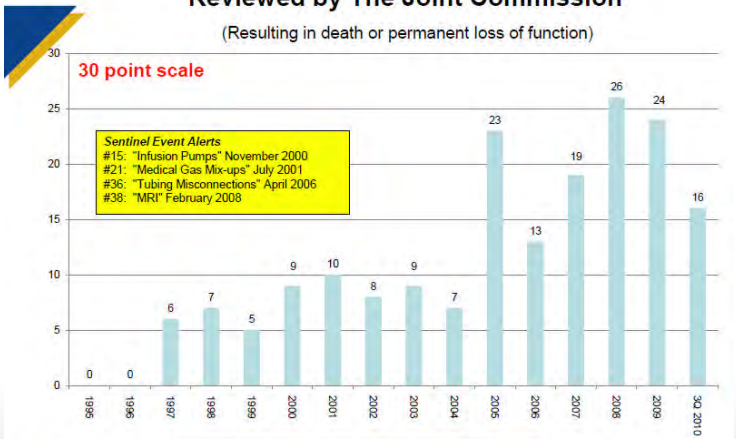
The Joint Commission

The reporting of most sentinel events to The Joint Commission is voluntary and represents only a small proportion of actual events. Therefore, these data are not an epidemiologic data set and no conclusions should be drawn about the actual relative frequency of events or trends in events over time.

Office of Quality Monitoring - 14

Medical Equipment-related Events Reviewed by The Joint Commission

(Resulting in death or permanent loss of function)



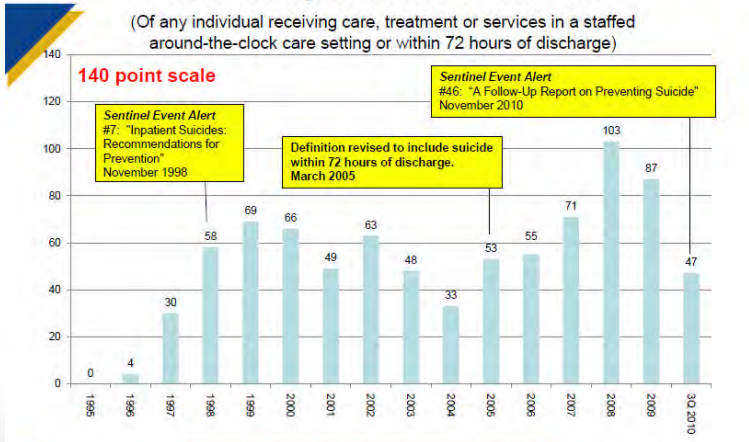
The Joint Commission

The reporting of most sentinel events to The Joint Commission is voluntary and represents only a small proportion of actual events. Therefore, these data are not an epidemiologic data set and no conclusions should be drawn about the actual relative frequency of events or trends in events over time.

Office of Quality Monitoring - 17

Suicide Events Reviewed by The Joint Commission

(Of any individual receiving care, treatment or services in a staffed around-the-clock care setting or within 72 hours of discharge)



The Joint Commission

The reporting of most sentinel events to The Joint Commission is voluntary and represents only a small proportion of actual events. Therefore, these data are not an epidemiologic data set and no conclusions should be drawn about the actual relative frequency of events or trends in events over time.

Office of Quality Monitoring - 25

Steps of CUSP

- Educate staff on Science of Safety
- Identify defects
  - Clinical or operational that you do not want to happen again
- Assign executive to adopt unit
  - Communication, attitudes, resources
- Learn from one defect per quarter
- Implement teamwork tools

So where are we now…

Summary

- Is a continuous process
- No longer just an “unfortunate” occurrence
- No longer satisfied to be below the national mean
  - Mean anchored us to mediocre performance
- Goal now is to strive for “zero”

MAHALO!
(Thank you!)