KHC Hospital Improvement Innovation Network

April 25, 2018
10 to 11 a.m.

HIIN Goals:
By September 2018, hospitals in the KHC HIIN will achieve 20% reduction in all-cause harm and 12% reduction in readmissions.

Announcements

National Walk at Lunch Day

Wednesday, April 25
12 PM - 1 PM

Share your photos on social media by using #NWLDKS
Agenda

• Introductions and Announcements

• KHC HIIN Data Update

• Hospital-Acquired Pressure Ulcers/Injuries: *Building skill and will at the bedside*

• Resources and Upcoming Events

Introductions

Special Guests

Jackie Conrad
MBA, BSN, RN
Cynosure Health

Betsy Lee
MSPL, BSN, RN
Cynosure Health

KHC Staff

Michele Clark
Program Director
mclark@khconline.org

Rob Rutherford
Senior Health Care Data Analyst
rrutherford@khconline.org
Wound Care Assessment Workshop
“Pearls” Presenters

• Jolene Morgan, APN
  Rush County Memorial Hospital
  La Crosse, KS

• Jennifer Gordon, RN
  Morris County Hospital
  Council Grove, KS

March KHC HIIN Webinar Recording

“Post-fall Management: Getting to Types of Falls, Repeat Falls, and Determining Preventability”
https://www.surveymonkey.com/r/KHC-HIIN-3-28-18-archive

• Examined post-fall practices as key interventions to reduce repeat falls
• Differentiated:
  ◦ Post Fall Huddles
  ◦ Post Fall Management
  ◦ Post Fall Documentation
  ◦ Incident Report

Patricia Quigley
Ph.D, ARNP, CRRN, FAAN, FAANP
Nurse Consultant
Next Steps from March webinar:
Identified by participating Kansas hospitals

- Explore/revamp post fall huddles.
- Post-fall meetings within 15 minutes.
- Make sure no one falls twice for the same reason.
- More patient involvement & discussion about what was different that caused them to fall.
- Group thinking approach.
- Change post fall huddles to include analysis/root cause.
- Don’t confuse contributing factors with root cause.
- Look at our fall prevention program.
- Present information to unit management.
- Present information to frontline staff.
- Pre-huddles or improved communication at shift change.
- Follow decision tree to determine preventability.
- Renewed effort to identify injury risk.
- Making sure change is made on care plan and that it is shared with the next shifts.
- Continuing to use this information to obtain more provider involvement.

Announcements

Take the #123forEquity Pledge to Act to Eliminate Health Disparities.
Join the #Partner4Health Equity Twitter Chat on April 25 from 1 to 2 pm CT.
Download the toolkit and share graphics throughout your organization, including web and social media.
Review topic resources on the HRET HIIN website and the AHA Social Determinants of Health.
**KFMC Readmissions Disparities Report**  
*Provided quarterly to all Kansas hospitals*

The Readmission Disparities Report is provided to help hospitals identify potential gaps or disparities in care using readmission rates.

This hospital-specific report provides stratification of the 30-day readmission rate KFMC has been providing you (developed from CMS Claims data) by age, gender, race, rural zip codes, and CMS Designated Socio-Economic Status (SES) zip codes.

This report is provided to your hospital’s Quality Net Administrator. The last report (for 2016Q1 to 2017Q1) was provided on February 6, 2018.

For questions or more information, contact:  
Michelle Sigmund, RHIT, CCS  
Kansas Foundation for Medical Care  
msigmund@kfmc.org or (785) 271-4166

**Announcements**

**Measures & Data Update**

- Reports  
- Milestones 7 and 8  
- Overall HIIN Progress  
- Focus Areas/Sprint

**Rob Rutherford**  
Senior Health Care Data Analyst  
Kansas Healthcare Collaborative  
RRutherford@khconline.org  
(785) 235-0763 x1326
Report Updates

- Final report package containing the monitoring report, analytic report, and side-by-side will be sent out today, 4/25

- Side-by-Side ignores data older than Dec. 2017

- Facility ID is on the upper right of the first page in the Analytic Report

Focus on Data Quality

- Things to look for:
  - Unusual numerator/denominators.
  - Run-chart always above baseline
  - NHSN and QHi mis-match
Report Updates

- Next month inactive process measures (data older than 6 months) will be removed from the Analytic reports.

- For example:
  - 24 Hour Skin Assessment
  - Central Line Insertion Protocol (CLIP)

NHSN Transfer

- We’ve recently discovered an issue where some NHSN data didn’t transfer QHi correctly

- Fix expected today

- Thank you to those that notified me of data not showing up correctly!
Improvement Calculator

- Improvement Calculator Update
- Refreshed version out in June or by request
  - New version 5.0 includes CEO Dashboard

### Preliminary Results

#### Improvement Calculator Dashboard

<table>
<thead>
<tr>
<th>Hospital (Site)</th>
<th>Most Recent Month Reported</th>
<th>Month Type</th>
<th>Cost Savings</th>
<th>HRET HIIN IMPROVEMENT CALCULATOR v5.0 on 04/23/2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>[Column]</td>
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<thead>
<tr>
<th>Month</th>
<th>Baseline Rate (per 1000)</th>
<th>Current Rate (per 1000)</th>
<th>% Change</th>
<th>Hypothesis Test</th>
<th>p-Value</th>
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<tbody>
<tr>
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HRET H1N Improvement Calculator v5.0 on 04/23/2018
Kansas HIIN Data Submission Schedule

<table>
<thead>
<tr>
<th>Outcome &amp; Process Measures for HACs occurring in:</th>
<th>Readmissions for index discharges in, and SSI for procedures performed in:</th>
<th>Submission Due</th>
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<tbody>
<tr>
<td>September, 2017</td>
<td>August, 2017</td>
<td>October 31, 2017</td>
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<td>November 30, 2017</td>
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<td>August 2018</td>
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<td>September 27, 2018</td>
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Upcoming Milestones

• **Milestone 7**
  - Data submission for all months through March 2018
  - Data due by June 15th

• **Milestone 8**
  - Data Submission for all months through May 2018
  - Meet HIIN goals for at least 5, preferably 8+ topics
  - Data due by August 24th
Current Progress (as of Apr. 23)

- Overall 12% Reduction in Harm!
- Saved 149 lives and $12,000,000!

Harms per 1,000 Discharges

Percent Improvement Year-to-Date

HRET HIIN Improvement Calculator v5.0 on 04/23/2018

HRET HIIN Improvement Calculator v5.0 on 04/23/2018
Focus Areas

KHC HIIN Currently...

- **Readmissions** (Prevent 390/Mo.)
- **Falls w/Injury** (Prevent 68/Mo.)
- **Post-Op Sepsis** (Prevent 4/Mo.)
- **CLABSI** (Prevent 4/Mo.)
- **CDI** (Prevent 25/Mo.)
- **Pressure Ulcers** (Prevent 15/Mo.)
HIIN PrU Progress

- 85% of hospitals Reporting
- ~53 Pressure Ulcers over baseline rate (discharge basis)
- At a cost of $900,000

Hospital-Acquired Pressure Ulcers/Injuries: Building skill and will at the bedside

Jackie Conrad
MBA, BSN, RN
Cynosure Health
Wound Care Assessment Workshop “Pearls”

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Pressure Injury Gaps

- Expertise Challenges
  - RNs and MDs lack expertise in staging and assessing wounds
  - How is competency in assessing risk, planning and delivering care measured?
- Failure to follow guidelines is frequently reported
  - RNs report that preventing HAPI was not their top priority


Elevating the value to nurses

- Nurses who had experience working with a patient with a high stage pressure injury prioritized preventative measures higher
- High attitude scores were attributed to adherence to guidelines
- Implications for practice
Tools to assess knowledge and attitudes

- **Pieper Pressure Ulcer Knowledge Test (PPUKT)**
  - 72 question True False
- **Pressure Ulcer Knowledge Assessment Tool (PUKAT)**
  - 26 multiple choice questions related to prevention
- **Attitudes towards Pressure Ulcer Prevention Tool (APuP)**
  - 11 questions 1-5 scale

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AHRQ Tool: Clinical Staff Attitudes Towards Pressure Ulcer Prevention

- This tool can be used to determine if misperceptions exist so that they can be addressed with education.

Pressure Injury Gaps

- Revisiting Competency

- Is it Either – Or?
- Or is it BOTH?

RN skills in preventing recognizing, staging and documenting wounds

System’s ability to deliver preventative skin care measures reliably
Building front line RN skills

- NDNQI is most popular and effective (Henry & Fortonda 2018)
- Teaching the “fruits of pressure injury”
- Skills fairs

Other creative approaches
- Pick a theme for a monthly staff email contests for identifying skin injuries
  - March Madness for Skin!
  - April Showers contribute to Moisture Associated Skin Damage – Can you tell the difference?

The “Fruits” of Pressure Ulcer Identification

**Stage 1**
Think Tomato!
Doesn’t blanch and return to original color. Has an unusual feel.

“Intact skin with non-blancheable redness.”

**Stage 2**
Think potato!
Top layer of skin gone, but not too deep.

“Partial thickness loss of dermis presenting as a shallow open ulcer.”

**Stage 3**
Think apple!
Wound open down to healthy part, but not to core.

“Full thickness tissue loss. Subcutaneous visible but bone, tendon or muscle are not exposed.”

**Stage 4**
Think peach!
Deep wound, open to core (bone, tendon).

“Full thickness tissue loss exposed bone, tendon or muscles.”

**Unstageable**
Think rotten peach!
You know it’s probably bad and very deep, but you can’t see how deep or to where.

“Full thickness tissues loss… base of ulcer is covered by slough and/or eschar.”

**Deep tissue injury**
Think eggplant!
People are not supposed to be purple or have a bruised appearance!

“Purple or maroon localized area of discolored intact skin.”

**Indeterminate or mucosal**
Think seedless grape!
No underlying structure to judge by but missing or damaged skin.
Build Front Line Champions

- 1-2 per unit or per shift
- Conduct prevalence studies
  - ½ day prevalence, ½ day QI or Education
- Acts as the “go-to person” for questions
- Tests new products
- Acts as an extension agent with helping staff adopt new practices.

Outcomes of staff education

- Empowerment of staff
  - Activating interventions i.e. specialty mattresses
- Improved attention to preventative activities
  - Early detection of stage 1
- Increased staff and patient satisfaction
- Improved communication
Tracking HAPI

**Incidence** describes the number or percent of patients developing a new PrI in your facility

- Can be underreported
- Reliance on documentation
- Small hospitals will have higher rates

**RATE**

\[ N = \frac{\text{pts with new HAPI}}{\text{pt admissions}} \]

http://www.ahrq.gov/professionals/systems/hospital/pressureulcertoolkit/putool5.html
How reliable is reporting?

- In a review of 2012 Medicare Data:
  - Among transfers with a POA PI reported, only 34% had a PI documented at the prior facility
  - Consistency of pressure injury documentation across interfacility transfers

- Allnurses.com, June, 2015 posting: “...that’s a heck of a lot of paperwork...do any other facilities fill out incident report for pressure ulcers? Does that even make sense?”

Prevalence

- **Prevalence** describes the number or percent of patients having a pressure ulcer at a single point in time.
- Best measure of the burden of care when providing for care and prevention measures.

- N = # of patients with stage II or greater (POA excluded)
- D = # of patients assessed on the day of the study
What’s best?

- AHRQ and NPUAP guidelines:
  - Incidence is best
  - Prevalence is reliable snapshot in time
  - Both methods have their drawbacks
- NDNQI reporting for national comparisons
  - Monthly rates can be determined for comparisons.

What can prevalence tracking do for you?

- Hardwire accurate staging
- Connect with staff
- Assure timely admission skin assessments and daily risk assessments
- Assess implementation of skin care prevention protocols
- Assess ongoing orientation changes
- Improve professionalism of caregivers with pro-active approach
- Gateway “drug” for professional advancement of staff
- What gets measured gets done!
- Ongoing preoccupation with high level care—everyone notices!
- “An ounce of prevention……”
Quotes from a Skin Team

What we do:
- Check for pressure ulcers
- Answer questions regarding other skin and wounds
- Help to facilitate interventions and consults as needed
- Serve as extra hands during the busy hours of a shift
- Discuss prophylaxis interventions and or treatments with bedside RN
- Complete hand checks on patients with air overlays

What we like:
- Learn about new products and how they work
- Discuss in terms of skin things that are improving and provide insight to areas of concern.
- Discuss the reaction of other staff members and efficacy issues with any new products
- The process of being a proactive resource rather than just reactive
- Teaching other staff members about products, the how, why, and when for each use.
- Becoming more knowledgeable in skin as a bedside RN

Why it works:
- We are a close group in this size hospital setting
- We enjoy the work, look forward to the process
- The audit becomes both a reflection of interventions and care outcomes
- Important discussions occur that change outcomes and processes
- It feels good to be valued and contribute
Getting Started – Who?

- Assign a coordinator
- Determine who will conduct the study
  - Team approach
  - Combination front line and exempt nurses
- Preventing bias
  - Assign team from another unit
The Team

• 2 observers
  - 1 lead individual specially trained or certified in wound care
    - CNS, Educator, WOCN
    - Unit manager or staff nurse champion
  - 1 individual to assist with turning
    - Staff nurse wound champion
    - Staff nurse orientee
    - Unlicensed staff
• 1 chart auditor, documenter (ideal, can be optional)

Study Procedure

• Pick a day to conduct the study each month
  - Ex. First Wednesday
  - All units should be surveyed on the same day
  - Pick a good day for staffing: orientees, students
Assess Each Patient on the Unit

- Inspect the skin of each patient from head to toe
- Look closely at all bony prominences
  - Peds and neonates, look at occiput
  - Visualize each heel using a handheld mirror
  - Palpate for temperature or consistency changes
- Examine the soft tissue under and around medical devices
- Assess the skin under skin folds in bariatric patients

Record Presence of Pressure Ulcers

- Skin Breakdown present on admission?
- If pressure ulcers are present:
  - Anatomical Location
  - Stage
  - Was this ulcer present on admission?

Process Measure Observations

• For patients determined to be at risk, are interventions in place?
  ▫ Positioning – turning, heels floated, HOB < 30
  ▫ Support surface, bed not over-padded
  ▫ Moisture management
  ▫ Nutritional support

• For patients with Medical Devices – are interventions in place?
  ▫ Padding
  ▫ Evidence of repositioning the device

Optimizing the Study Process

• Use the prevalence study to teach
  ▫ Orientees, rotate staff to assist, use student nurses

• Use the prevalence study to assess practice
  ▫ Observe for patterns
  ▫ Select interventions to study

• Assess for other measures
  ▫ Restraint prevalence
  ▫ Environmental safety
  ▫ Use of white boards
Building Skill and Will at the Bedside

Benefits of PrU Prevalence Study

- **Structural process**
  - Real time data collection & intervention
  - Staff involved – learning opportunity, use orientees, light duty

- **Demonstrates commitment to HAPU and teamwork**
  - Leadership and staff partnership in monthly rounding team

- **Richness of data**
  - Quantitative outcome and process measure data on ulcers, implementation of interventions
  - Qualitative data on staff skills, beliefs, abilities and barriers encountered in preventing pressure ulcers
Financial Cost of Prevalence Study Manpower

- Prevalence study cost for 30 bed unit staffed with 2 frontline nurses
  - 2 staff x 4 hours x $32/hr = $256/month
- Prevalence study cost for 30 bed unit with one front line nurse and one exempt nurse (educator, manager, CNS)
  - 1 staff x 4 hours x $32/hr = $128/month
- Prevalence study cost for 10 bed unit with one front line nurse
  - 1 staff x 3 hours x $32/hour = $96/month
- Prevalence study cost for 3 bed CAH with one front line nurse
  - 1 staff x 1.5 hours x $32/hour = $48/month
- Prevalence study cost for 3 bed CAH with exempt nurse
  - Cost is absorbed by exempt leader = $0

- Cost of one Stage III Pressure Ulcer = $38,000-$55,000
- Cost avoided by preventing any pressure injuries = $17,000

- Prevalence Study Costs are estimates based upon average US RN hourly rate

Advice for others

- Engage your team with education either by yourself or invite vendors in for education – nurses love to learn
- Do whatever you can to make sure they feel valued – because they are and their input and work is invaluable!
Resources for Building Front Line Champions

- Complementary NPUAP webinar recordings:
  - FAQs about Pressure Injury Staging
  - Unavoidable Pressure Injuries, Terminal Ulcers and Skin Failure
  - OR Positioning and Pressure Injury Prevention
  - Why is this wound not healing?
  - Considerations for Bariatric Patients in Pressure Injuries
  - Nutrition & Pressure Injuries
    http://www.npuap.org/resources/educational-and-clinical-resources/complimentary-educational-webinars/

Resources

- HRET HIIN HAPI Resources:
  http://www.hret-hiin.org/topics/pressure-ulcers.shtml

- NDNQI Pressure Ulcer Training
  https://members.nursingquality.org/NDNQIPressureUlcerTraining/Module1/Default.aspx

- NPUAP Complimentary Webinars
  http://www.npuap.org/resources/educational-and-clinical-resources/complimentary-educational-webinars/

- AHRQ Resources and RN Attitude and Knowledge Assessments
Resources & Upcoming Events

- Resources
- Upcoming Events
- Q&A
- Wrap Up

Michele Clark
Program Director
Kansas Healthcare Collaborative
mclark@khconline.org
(785) 235-0763 x1321

Help YOUR Hospital Sprint

LESSONS LEARNED FROM YOUR HRET HIIN PBERS:

ADD: Hypoglycemia

CDI

CAUTI

CLABSI

MRSA-MDR

MRSA
Hospital stories

Share a brief story about an innovative intervention or process that your team implemented to improve patient care.

- Why did you hospital choose to address this opportunity?
- What intervention(s) were developed, and what were the results?

Contact Michele Clark or Chuck Duffield at Kansas Healthcare Collaborative
(785) 235-0763

New Resource!
Hospital Elder Life Program Mobility Change Package and Toolkit

http://www.hret-hiin.org/resources/display/hospital-elder-life-program-mobility-change-package-and-toolkit
The training is intended for:
- Physicians, nurses, and pharmacists
- Public health professionals, including health educators and interdisciplinary public health practitioners
- Students in health-related fields

Promotional Toolkit
https://health.gov/hcq/training-pathways.asp

Register Today at www.khconline.org

10th Annual Summit on Quality
May 4, 2018
Hyatt Regency - Wichita, KS
May 5 is World Hand Hygiene Day
Health care-associated infections, infections acquired during health care delivery, are common and are a risk factor for developing sepsis but we can prevent this. Effective hand hygiene plays a key role. On world hand hygiene day (5 May), the focus for everyone should be on prevention of sepsis in health care.

World Health Organization
Save Lives: Clean Your Hands
5 May 2018
‘Prevent Sepsis in Health Care’

Tools and resources at:
http://www.who.int/infection-prevention/campaigns/clean-hands/5may2018/en/
* Posters *Photographs *Slide set
* Banners * Engagement/activity tool for IPs and more!

May 15, 2018
Kansas Workshop:
Hospital Antimicrobial Stewardship
Four Points by Sheraton Manhattan, KS

A team-based, program-building workshop

• Bring your hospital ASP team
• Travel scholarships are available
• Registration is still open

https://www.khconline.org/events/event-descriptions/326-kansas-asp-workshop
Upcoming Events

Upcoming HIIN Webinars

GP QIN | TeamSTEPPS 2.0 Essentials Training for Hospital Staff
April 26 ● 2:00 p.m. to 4:00 p.m.  [Register here]

National Partnership for Action to End Health Disparities | Strategies for Building and Strengthening the CHW Effort in Your Area: A Case Study from Utah
April 26 ● 1:00 to 2:00 p.m.  [Register here]

HRET HIIN: Data Driven Techniques to Enhance Physician Participation
April 26 ● 2:00 to 3:00 p.m.  [Register here]

WSHA: Patient Safety Safe Table -- #123 for Equity Training Symposium
May 2 ● 11:00 am to 4:00 p.m.  [Register here]

HRET HIIN: Measurement Matters: NHSN CDI Surveillance Definition Review
May 3 ● 1:00 p.m. to 2:30 p.m. CT  [Register here]

HRET HIIN: HRET HIIN Readmissions Sepsis Fishbowl Series: Part 2
May 6 ● 11:00 to 12:00 p.m. [Register here]

Mark Your Calendars!

KHC HIIN Webinar
May 23, 2018

Save the Date!
KHC HIIN Sepsis Champion Workshop
June 27
Four Points by Sheraton
Manhattan, KS
(in place of June KHC HIIN webinar)
Questions?

Contact your KHC Team
Please provide feedback to this webinar
Let us know your next steps.

https://www.surveymonkey.com/r/KHC-HIIN-042518
ALIGNING DATA AND INSIGHTS FOR ACTION

Health Research and Educational Trust: Hospital Improvement Innovation Network (HIIN)

HRET HIIN is a contract funded by CMS that aims at continuing efforts to reduce all-cause inpatient harm by 20% and readmissions by 12%.

Use the information below to identify potential interventions and best practices shared across the field to reduce the most pressing national harms.

STATUS OF MOST PRESSING NATIONAL HARMS:

- Adverse Drug Events (ADE) - Hypoglycemia
  - Current Improvement: 17%
  - Partnership for Patients Goal: 20%
- Clostridium difficile Infection (CDI)
  - Current Improvement: 20%
  - Partnership for Patients Goal: 12%
- Catheter-Associated Urinary Tract Infection (CAUTI)
  - Current Improvement: 12%
  - Partnership for Patients Goal: 20%
- Central Line-Associated Bloodstream Infection (CLABSI)
  - Current Improvement: 20%
  - Partnership for Patients Goal: 18%
- Multi-Drug Resistant Organisms (MDRO) - methicillin-resistant Staphylococcus aureus (MRSA)
  - Current Improvement: 2%
  - Partnership for Patients Goal: 10%
- Sepsis
  - Current Improvement: 12%
  - Partnership for Patients Goal: 20%

This information is valid as of March 2018.

PATH TO IMPROVEMENT

1. Review data for topics listed above
2. Prioritize topic areas with the highest rates
3. Stratify data and identify root cause
4. Develop strategy for intervention and test for improvement
5. If at first you don't succeed, try a new test of change

Share best practices for sustainability and advance progress in improving quality and patient safety.
**LESSONS LEARNED FROM YOUR HRET HIIN PEERS:**

<table>
<thead>
<tr>
<th>ADE: Hypoglycemia</th>
<th>CDI</th>
<th>CAUTI</th>
<th>CLABSI</th>
<th>MDRO-MRSA</th>
<th>Sepsis</th>
</tr>
</thead>
<tbody>
<tr>
<td>Educate patients and families regarding hypoglycemia rescue protocols</td>
<td>Focus on Diagnostic Stewardship to guide laboratory and clinical diagnosis of CDI</td>
<td>Stop inserting and/or leaving indwelling urinary catheters unless clinically indicated, particularly in the ED, ICU and PACU. Ask if there is a need for strict I &amp; O in critical care patients.</td>
<td>Stop leaving central lines in place that are not clinically indicated</td>
<td>Engage all direct care staff and providers in peer-supported hand hygiene adherence efforts</td>
<td>Focus on early identification and treatment, especially in the small/CAH subgroup</td>
</tr>
<tr>
<td>Adjust the insulin regimen after a single episode of hypoglycemia (Glucose &lt; 70 mg/dl)</td>
<td>Develop a process to minimize testing of patients at a low probability for CDI</td>
<td>Stop culturing asymptomatic patients</td>
<td>Stop routinely drawing blood cultures from the central line</td>
<td>Involve and educate patients, families and the public about the risk of unnecessary antibiotic use and community resistance patterns</td>
<td>Start sepsis screening in PACU with a focus on high risk patients - post-op, immuno compromised, those with devices</td>
</tr>
<tr>
<td>Use the assessment tool with hospitals that have high rates to help them understand what is driving ADE Hypoglycemia in their hospital</td>
<td>Establish cleaning protocols that are effective against CDI spores</td>
<td>Consider utilizing alternatives such as the female external catheter</td>
<td>Consider blood culture specimen diversion</td>
<td>Consider matching decolonization strategies to risk assessment and surveillance findings to target appropriate units and populations</td>
<td>Complete enhanced recovery after surgery (ERAS) protocol for each patient</td>
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