



**METABOLIC AND BARIATRIC SURGERY
ACCREDITATION AND QUALITY IMPROVEMENT PROGRAM**

How to Put the “Quality” in MBSAQIP Standard 7.2: “QI Initiatives”

Teresa Fraker, MS, RN, CPHQ

Program Administrator, MBSAQIP

Division of Research & Optimal Patient Care (DROPC)

American College of Surgeons (ACS)

Getting Started!

Read Standard 7.2 carefully

MBSAQIP
METABOLIC AND BARIATRIC SURGERY
ACCREDITATION AND QUALITY IMPROVEMENT PROGRAM

A QUALITY PROGRAM
of the AMERICAN COLLEGE
OF SURGEONS

Optimal Resources for
Metabolic and Bariatric
Surgery

2019 Standards

facs.org/mbsaqip

ASMBMS American Society for
Metabolic and Bariatric Surgery

AMERICAN COLLEGE OF SURGEONS
Inspiring Quality.
Highest Standards. Better Outcomes.
100-years

7.2 Quality Improvement Initiatives

Definition and Requirements

The goal for MBSAQIP-Accredited centers is to provide safe, efficacious, and high-quality care to each patient at all times. To achieve this goal, it is imperative to develop a culture of collaboration and safety among all MBS Committee members at the center. Quality improvement (QI) emphasizes a continuous, multidisciplinary effort to improve the process of care and its outcome. Thus, QI must be supported by a reliable method of data collection that consistently obtains valid and objective information necessary to identify opportunities for improvement at the center. The semiannual risk-adjusted reports (SAR), non-risk-adjusted reports, and other data sources (for example, patient experience scores) are valuable tools to evaluate areas for improvement for the center and must be used to identify pertinent QI initiatives. These initiatives must change structure, processes, and/or clinical pathways within the center.

With oversight from the MBS Director, all MBSAQIP-Accredited centers must measure, evaluate, and improve their performance through at least one quality improvement initiative each year. The timeline for completion of each QI initiative is variable depending on the scope of the project, and must be determined by the MBS Committee. However, a new QI initiative must be implemented each year, even if a previous initiative is still underway.

Centers must adopt a consistent methodology for quality improvement initiatives. The methodology may vary from center to center depending on the unique needs and expectations of each. Various QI methodologies can be adopted to support quality improvement initiatives. Further information about QI methodologies can be found on the MBSAQIP website, facs.org/quality-programs/mbsaqip/resources.

Renewal centers must first review their risk-adjusted and non-risk-adjusted clinical outcomes data provided by the MBSAQIP Registry to identify quality improvement initiatives, and must prioritize QI initiatives that focus on improving surgical outcomes. **Centers found to be a high outlier on the semiannual risk-adjusted report (SAR) must develop a QI initiative designed to address the high outlier status.** If the center is a high outlier in more than one model on the semiannual risk-adjusted report (SAR), the MBS Committee must prioritize these clinical issues and the next QI initiative must address the greatest risk to patient safety. Although only one QI initiative is required each year, the MBSAQIP encourages the use of multiple QI initiatives to address issues related to clinical outcomes and patient

safety when warranted. If further investigation reveals a QI initiative addressing a high outlier status is unwarranted (for example, concurrent data shows subsequent resolution of the issue), the center may select an alternative QI initiative driven by other data or process reviews. However, the center must provide written justification to support this decision.

Initial centers, and renewal centers that do not have a high outlier status on the semiannual risk-adjusted report (SAR), must develop quality improvement initiatives prioritizing other issues related to clinical outcomes and patient safety. If no such issues are readily identifiable, QI initiatives must target other areas for improvement, including, **but not limited to:** internal processes, clinical pathways, patient education, patient experience, or other relevant issues related to providing safe, efficacious, and high-quality care to metabolic and bariatric patients.

Quality Improvement Outline

These 6 steps outline the basic process for completing a quality improvement initiative that satisfies the requirements outlined above. **Further information about quality improvement, including a detailed review of this 6 step process, can be found on the MBSAQIP website, facs.org/quality-programs/mbsaqip/resources.**

1. **Review Data**
 - a. Semiannual risk-adjusted reports (SAR)
 - b. Non-risk-adjusted reports
 - c. Internal data
2. **Identify the Problem**
 - a. High outlier status
 - b. Other areas for improvement
3. **Propose Intervention**
 - a. Discuss contributing factors
 - b. Root cause analysis
4. **Choose Quality Improvement Methodology**
 - a. MBSAQIP-Accredited centers are able to use any consistent quality improvement methodology that satisfies their unique needs
 - b. Establish a timeline for review and metrics to track progress
5. **Implement Intervention & Monitor Data**
 - a. Consistently implement the intervention
 - b. Monitor data
6. **Present Results**
 - a. Gather all documentation and data
 - b. Review progress
 - c. Summarize the findings and results of the quality improvement initiative

Standard 7.2 Verbiage

Quality Improvement Outline

These 6 steps outline the basic process for completing a quality improvement initiative that satisfies the requirements outlined above. Further information about quality improvement, including a detailed review of this 6 step process, can be found on the MBSAQIP website, facs.org/quality-programs/mbsaqip/resources.

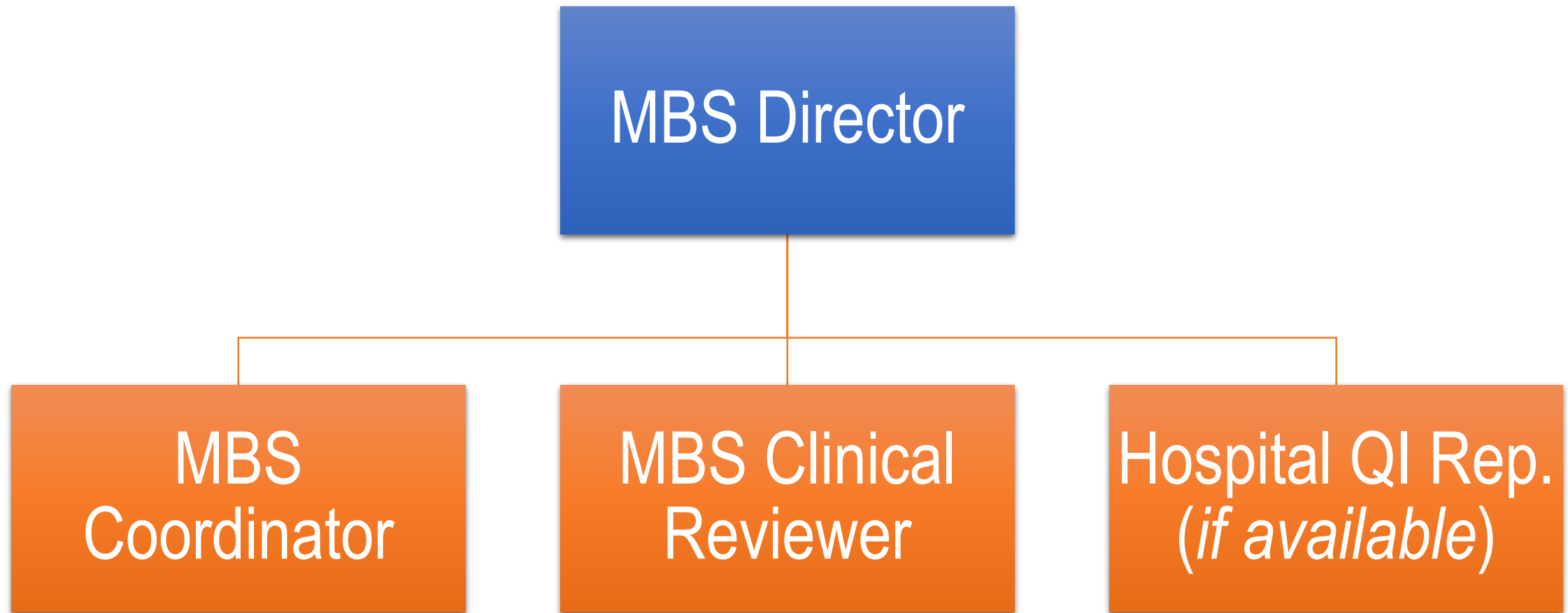
1. **Review Data**
 - a. Semiannual risk-adjusted reports (SAR)
 - b. Non-risk-adjusted reports
 - c. Internal data
2. **Identify the Problem**
 - a. High outlier status
 - b. Other areas for improvement
3. **Propose Intervention**
 - a. Discuss contributing factors
 - b. Root cause analysis
4. **Choose Quality Improvement Methodology**
 - a. MBSAQIP-Accredited centers are able to use any consistent quality improvement methodology that satisfies their unique needs
 - b. Establish a timeline for review and metrics to track progress
5. **Implement Intervention & Monitor Data**
 - a. Consistently implement the intervention
 - b. Monitor data
6. **Present Results**
 - a. Gather all documentation and data
 - b. Review progress
 - c. Summarize the findings and results of the quality improvement initiative

Standard 7.2: The 5 Process Steps

- 1 Review Data to Identify the Problem
- 2 Write a Problem Statement
- 3 Choose & Implement Performance Improvement Methodology & Metrics
- 4 Implement intervention and monitor data
- 5 Present QI Initiative Summary



Before you get started: Assemble a CORE QI Team



1. Review Data

Data Sources

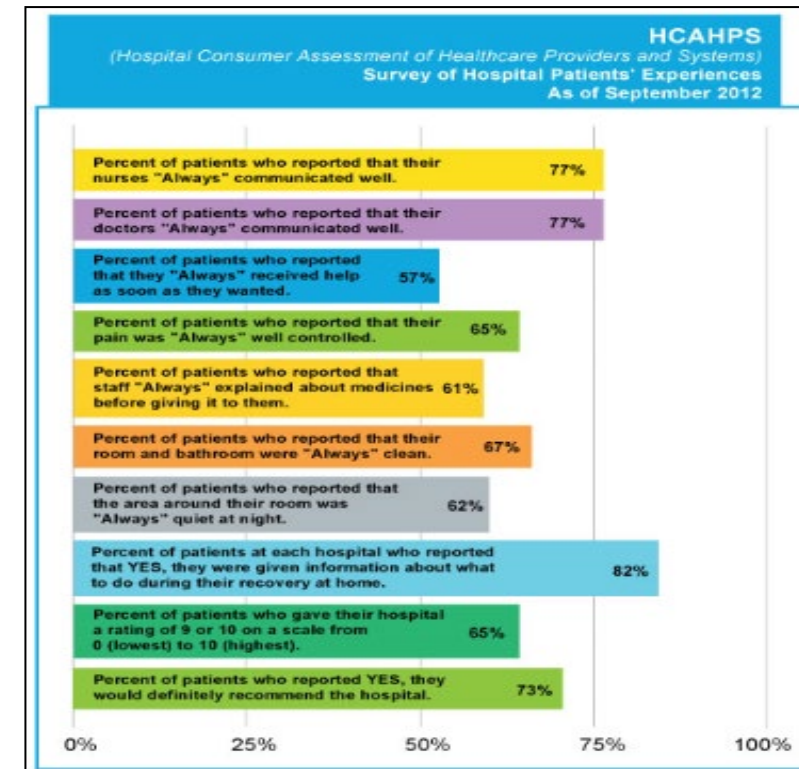
1. SAR Site Summary Report

MBSAQIP 07/01/2013 - 06/30/2014 Semiannual Report: Site Summary											
MBSAQIP Center Name										Site Number	
Laparoscopic Sleeve Gastrectomy											
	Total Cases	Observed Events	Observed Rate	Pred** Obs. Rate	Expected Rate	Odds Ratio	CI*** Lower	Upper	Outlier Decile	Comment*	
LSG Morbidity	242	8	3.31%	3.02%	2.18%	1.41	0.73	2.74	No	8	As Expected
LSG All Occurrences Morbidity	242	9	3.72%	4.18%	5.14%	0.80	0.48	1.34	No	2	As Expected
LSG Leak	242	0	0.00%	0.25%	0.39%	0.64	0.15	2.62	No	1	Exemplary
LSG Bleeding	242	1	0.41%	0.64%	0.87%	0.73	0.24	2.18	No	2	As Expected
LSG SSI	242	1	0.41%	0.40%	0.39%	1.03	0.26	4.15	No	7	As Expected
LSG All Cause Reoperation	242	2	0.83%	0.96%	1.09%	0.88	0.37	2.14	No	4	As Expected
LSG Related Reoperation	242	1	0.41%	0.63%	0.79%	0.79	0.29	2.18	No	2	As Expected
LSG All Cause Intervention	242	0	0.00%	0.35%	0.59%	0.59	0.17	2.09	No	1	Exemplary
LSG Related Intervention	242	0	0.00%	0.29%	0.48%	0.59	0.15	2.37	No	1	Exemplary
LSG All Cause Readmission	242	6	2.48%	2.98%	3.72%	0.80	0.48	1.39	No	2	As Expected
LSG Related Readmission	242	5	2.07%	2.29%	2.62%	0.87	0.46	1.66	No	4	As Expected
Laparoscopic Roux-en-Y Gastric Bypass											
	Total Cases	Observed Events	Observed Rate	Pred** Obs. Rate	Expected Rate	Odds Ratio	CI*** Lower	Upper	Outlier Decile	Comment*	
RYGB Morbidity	52	6	6.52%	5.47%	3.13%	1.80	0.82	3.93	No	9	As Expected
RYGB All Occurrences Morbidity	52	8	8.70%	8.52%	8.17%	1.05	0.57	1.92	No	6	As Expected
RYGB Leak	52	1	1.09%	0.44%	0.25%	1.78	0.34	9.39	No	9	As Expected
RYGB Bleeding	52	1	1.09%	1.56%	1.79%	0.87	0.35	2.18	No	3	As Expected
RYGB SSI	52	2	2.17%	1.54%	0.75%	2.07	0.54	7.88	No	9	As Expected
RYGB All Cause Reoperation	52	4	4.35%	3.07%	2.28%	1.36	0.63	2.94	No	9	As Expected
RYGB Related Reoperation	52	3	3.26%	2.42%	1.88%	1.30	0.54	3.10	No	9	As Expected
RYGB All Cause Intervention	52	0	0.00%	0.67%	1.17%	0.57	0.13	2.55	No	1	Exemplary
RYGB Related Intervention	52	0	0.00%	0.63%	1.07%	0.58	0.13	2.70	No	1	Exemplary
RYGB All Cause Readmission	52	4	4.35%	5.07%	5.75%	0.88	0.46	1.66	No	3	As Expected
RYGB Related Readmission	52	3	3.26%	3.89%	4.48%	0.85	0.42	1.78	No	3	As Expected

2. Online Benchmarking Reports

30-Day Morbidity and Mortality Report			
Reports case counts and percentages of morbidities and mortalities. Displays surgeon specific, site specific, and comparison data			
Reporting Period: 07/01/2015 - 06/30/2016			
CPT® Group: All Operations			
Total # of Cases: Site = 12 / Comparison = 59			
	SITE		COMPARISON
Total Number of Cases ¹	12	59	
Mortality			
Mortalities	2 16.7%	3 5.1%	
Morbidity			
Cases with one or more occurrences	4 33.3%	26 44.1%	
GENERAL POSTOPERATIVE OCCURRENCES			
Cases With Wound Occurrences			
Superficial Incisional SSI	0 0%	4 6.8%	
Deep Incisional SSI	0 0%	0 0%	
Organ/Space SSI	2 16.7%	4 6.8%	
Wound Disruption	2 16.7%	2 3.4%	
Cases With Respiratory Occurrences			
Pneumonia	0 0%	2 3.4%	
Intraoperative OR Postoperative Unplanned Intubation	0 0%	1 1.7%	
Pulmonary Embolism	0 0%	0 0%	
On Ventilator > 48 hours	0 0%	1 1.7%	
Cases With Urinary Tract Occurrences			
Progressive Renal Insufficiency	0 0%	0 0%	
Acute Renal Failure	0 0%	0 0%	
Urinary Tract Infection	0 0%	2 3.4%	

3. Internal Data (e.g., patient experience scores)



Benchmark Data

IMPORTANT: Dedicate time to learn about your SAR data!

The screenshot shows the MBSAQIP Reports menu. The 'Current SAR' option is circled in red. The menu items are:

- Home
- Reports
 - Case Details & Custom Fields Report
 - Custom Fields Manual
 - Instructions
 - Basic Excel in MBSAQIP
 - Excel Tutorial
 - Current SAR**
 - SAR Archive
 - Interactive Site Summary
 - Case Occurrences Report
 - Case details filtered by SAR, type, and model
 - Non-Risk Adjusted MBSAQIP Online Report Tutorial
 - Instructions
- Program Resources
- QI Tools
- DataPortal

The screenshot shows the July 2018 Semiannual Report page. The title is "July 2018 Semiannual Report". Below the title, it says "The following are a list of published documents for July 2018 Semiannual Report." The list of documents is:

- ✓ July 2018 Semiannual Report
- ✓ Model Reports
- ✓ Site List
- ✓ Powerpoint Presentation
- ✓ Site-Level QCDR Measures
- ✓ MBSAQIP Semiannual Report Supplement QCDR Model Reports
- ✓ Tutorials - Interpreting the MBSAQIP SAR**
- ✓ Tutorials - Statistical Modeling**
- ✓ Site Summary Report

Benchmark Data

If Outlier = “High”, then QI project required*

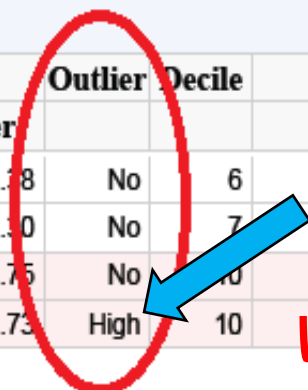


07/01/2012 - 06/30/2013 Semiannual Report: Site Summary

Site Number:

Laparoscopic Sleeve Gastrectomy

	Total	Observed		Pred**	Expected	Odds	C.I.***		Outlier	Decile	Performance*
	Cases	Events	Rate	Obs. Rate	Rate	Ratio	Lower	Upper			
LSG All Cause Intervention	158	1	0.63%	0.65%	0.66%	0.98	0.29	3.28	No	6	As Expected
LSG Related Intervention	158	1	0.63%	0.51%	0.44%	1.15	0.31	4.20	No	7	As Expected
LSG All Cause Readmission	158	9	5.70%	4.14%	2.74%	1.55	0.87	2.75	No	10	Needs Improvement
LSG Related Readmission	158	8	5.06%	3.42%	1.81%	1.93	1.00	3.73	High	10	Needs Improvement



Benchmark Data

Drill down using Case Occurrences Report

Risk-Adjusted Case Occurrences Report

SAR Period: Type: Model:

Case Occurrences for LSG All Occurrences Morbidity 07/01/2014 - 06/30/2015

- With Complications
- Without Complications

Category	Count	Percentage
Without Complications	59	96.7%
With Complications	2	3.3%

Cases for LSG All Occurrences Morbidity

61 Total Cases

Case Selection: All Only With Occurrence None

Clicking on the case number will open the workstation case form in a new window.

Case #	Had Occurrence	Expected
<input checked="" type="checkbox"/> 100491	yes	0.0416647705
<input checked="" type="checkbox"/> 100587	yes	0.062596103
<input type="checkbox"/> 100487	no	0.0883560562
<input type="checkbox"/> 100490	no	0.0521090032
<input type="checkbox"/> 100492	no	0.052349712
<input type="checkbox"/> 100498	no	0.0291365429
<input type="checkbox"/> 100502	no	0.0378291155
<input type="checkbox"/> 100503	no	0.0306191934

Prioritize Patient Safety and Outcomes

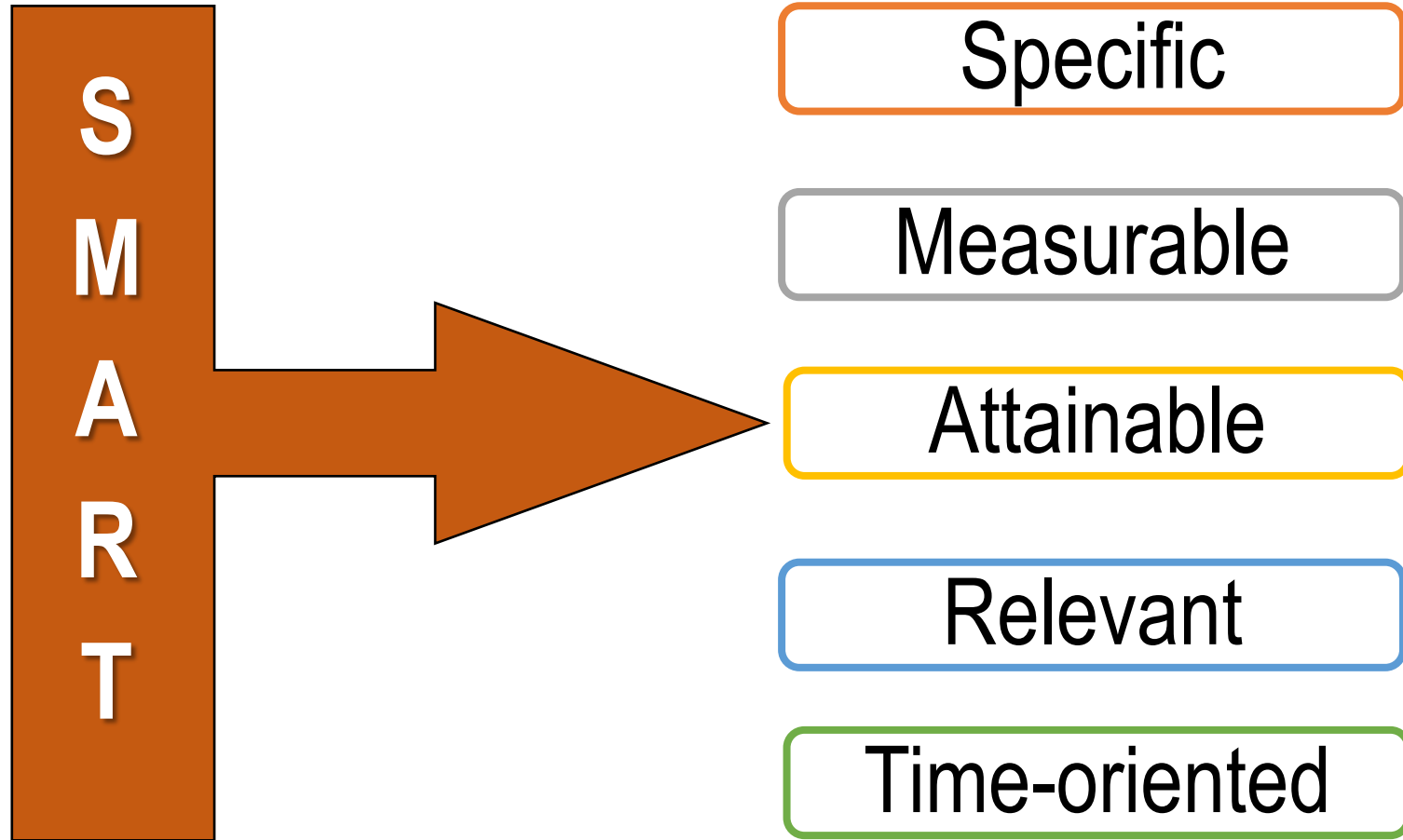
If Outcomes Data does not reveal a problem, ask:

- Gaps in resources or care services?
- Issues regarding timeline of care?
- Gaps in patient compliance or follow-up?
- Issues related to patient satisfaction or procedure effectiveness?
- Educational gaps for patients or staff?

Write a Problem Statement

3 things that must be included in the Problem Statement:

1. Clearly identify a specific problem you want to solve through your QI Project.
2. Identify your baseline and goal metrics.
3. Identify the timeline for meeting this goal.



Problem Statement Example

2. Identify
Problem

Our predicted (adjusted) observed rate for All Cause Readmission for LSG was 7.2% in the 2015 calendar year, which makes us a high outlier in this model. Our goal is to lower our LSG readmission rate to the expected rate of 3.72% by December 31, 2016.

Propose Intervention

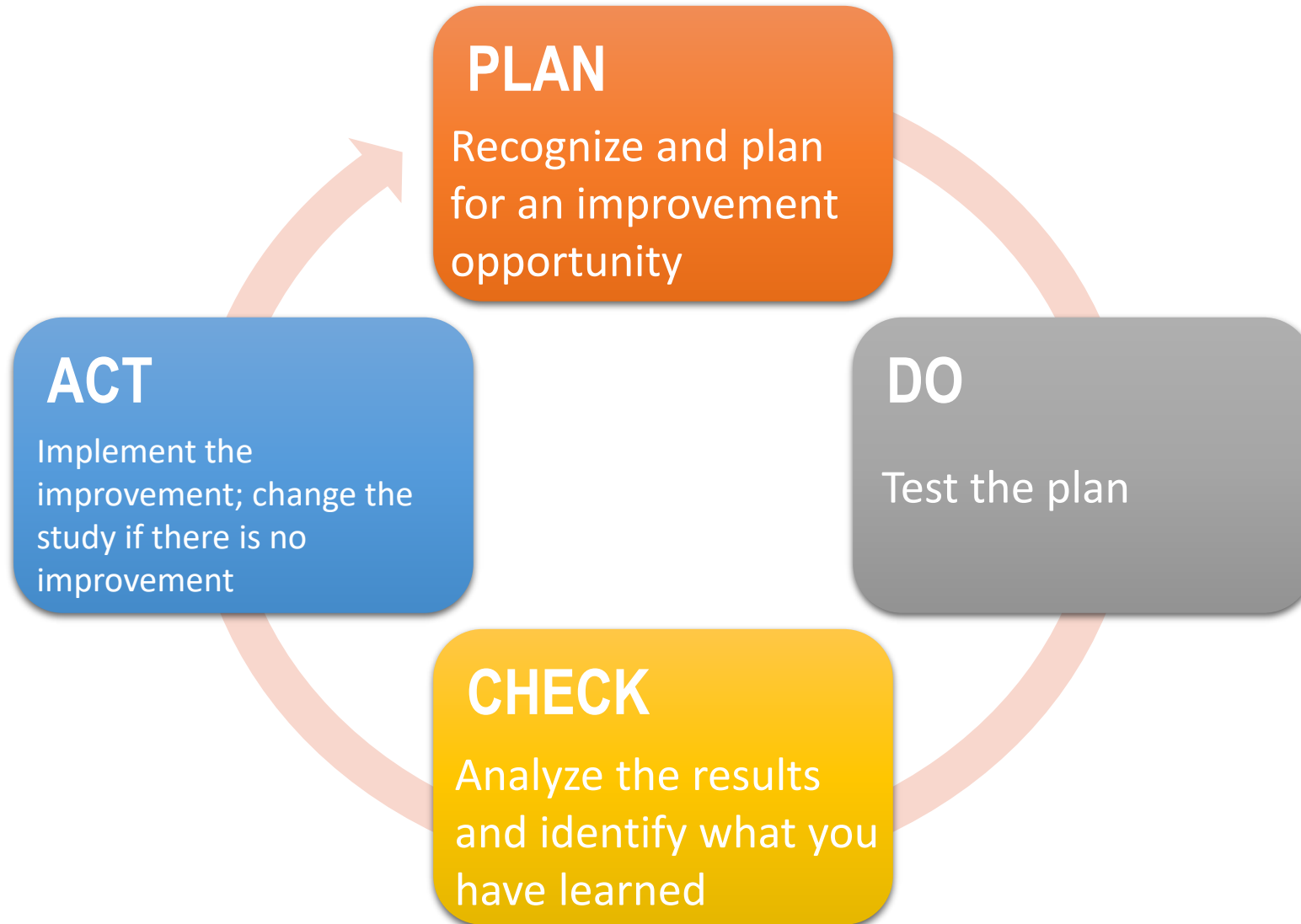
- Gather all members of the MBS Committee to discuss all possible factors contributing to the problem
- Conduct literature review--may reference ASMBS Guidelines and Position Statements <http://asmbs.org/resource-categories/position-statements>
- May choose to implement a Root Cause Analysis tool such as “The 5 Whys”, “SIPOC”, or a “Fishbone Diagram”
- Document a plan for intervention

PI Tools and Metrics

- Choose Process Improvement (PI) Tool or standardized methodology
- Identify metrics and measurement tool
 - ✓ Choose/create a measurement tool (MBSAQIP Data Registry, Survey, Excel Spreadsheet, etc.)
 - ✓ Create a data point using MBSAQIP Data Registry If you want to capture a specific data point
 - In the Data Registry **Custom Fields** and extract that data via the **Case Details and Custom Fields Report**
- Establish project calendar

PDC(S)A

4. Choose PI
Methodology &
Metrics



PDC(S)A

The benefits of repeated cycles

- Belief that change will result in improvement
- Opportunities for 'failures' without impacting performance
- Minimizes resistance when implemented
- Adapts to changing environment

DMAIC

4. Choose PI
Methodology &
Metrics

Define

- Look at data sources to identify an area of improvement related patient safety, efficacy, or experience.

Measure

- Quantify the problem through a methodical approach to defining defects, metrics, and a detailed process map.

Analyze

- Identify sources of variation and determine root causes.

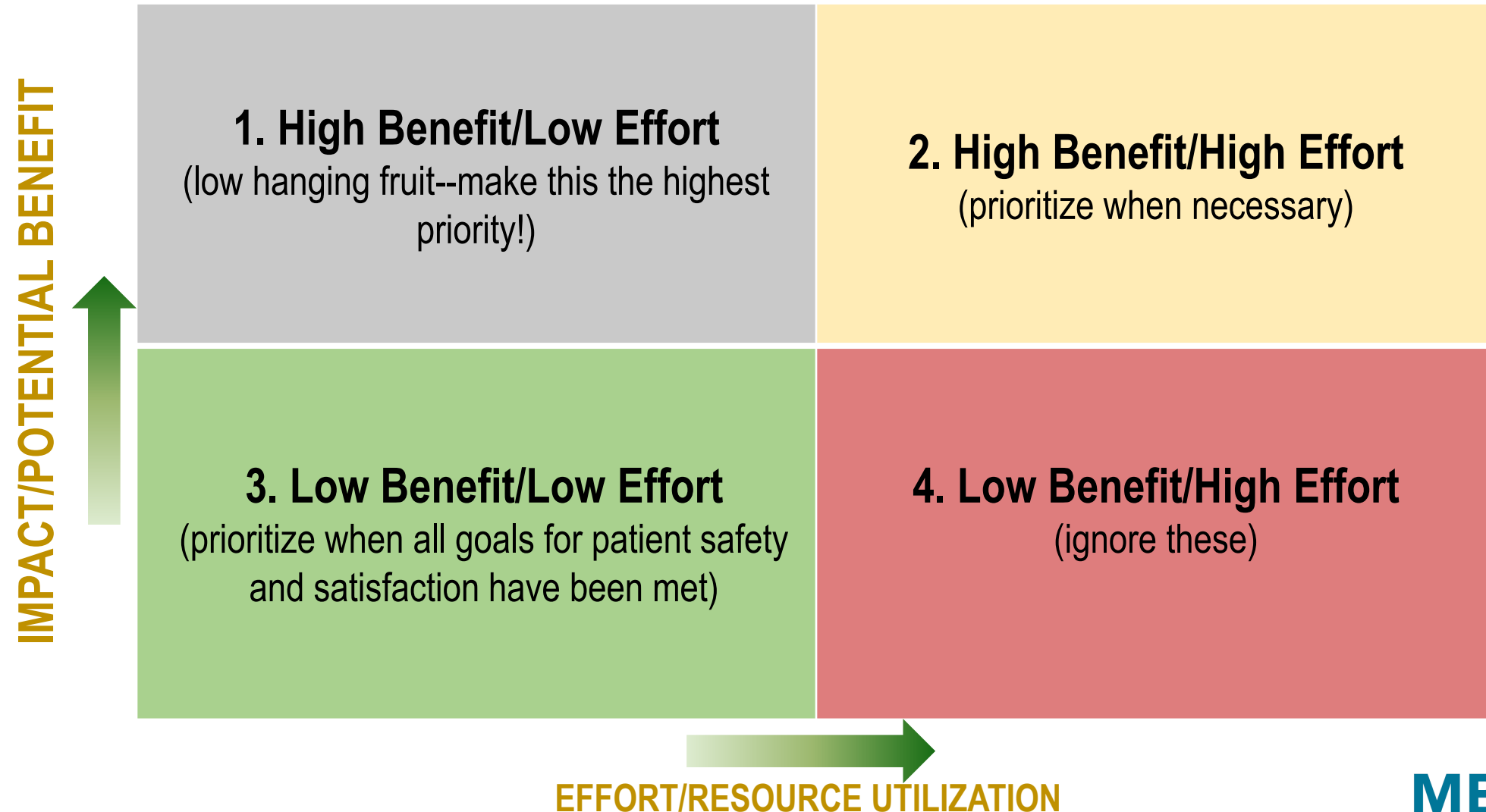
Improve

- Develop intervention to address the root causes that are critical to quality.

Control

- Monitor and validate the intervention to ensure a positive outcome, unintended consequences and sustainability.

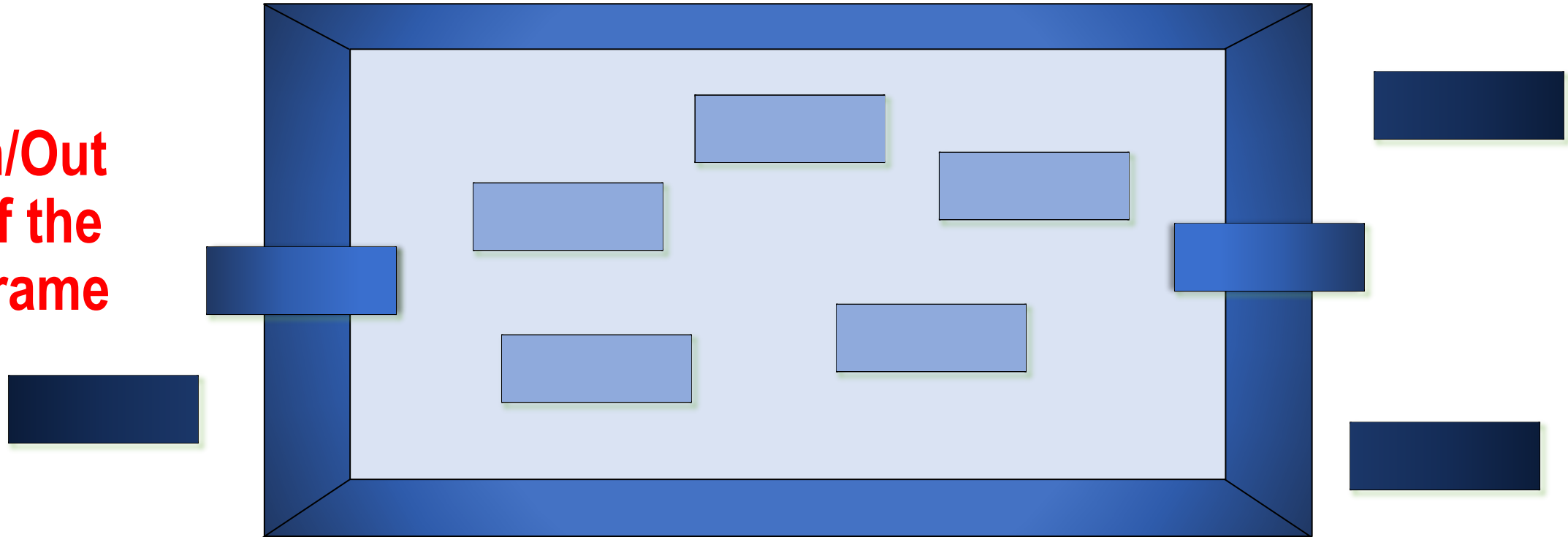
Prioritization Matrix *(Define phase of DMAIC)*



Bounding Exercise

Draw a large square picture frame on a flip chart – This metaphor helps the team identify what falls inside the picture of their project and what falls out.

**In/Out
of the
Frame**



More Of/Less Of: Clinic Patient Throughput Example

More of...

Improved patient satisfaction surveys

Patients praising reduced wait-time

Transparent communication to patients about wait-time

Staff working together as a team

Prompt room assignment

Coordination of check-in/check-out

Less of...

Patients complaining to manager

Patients leaving without being seen

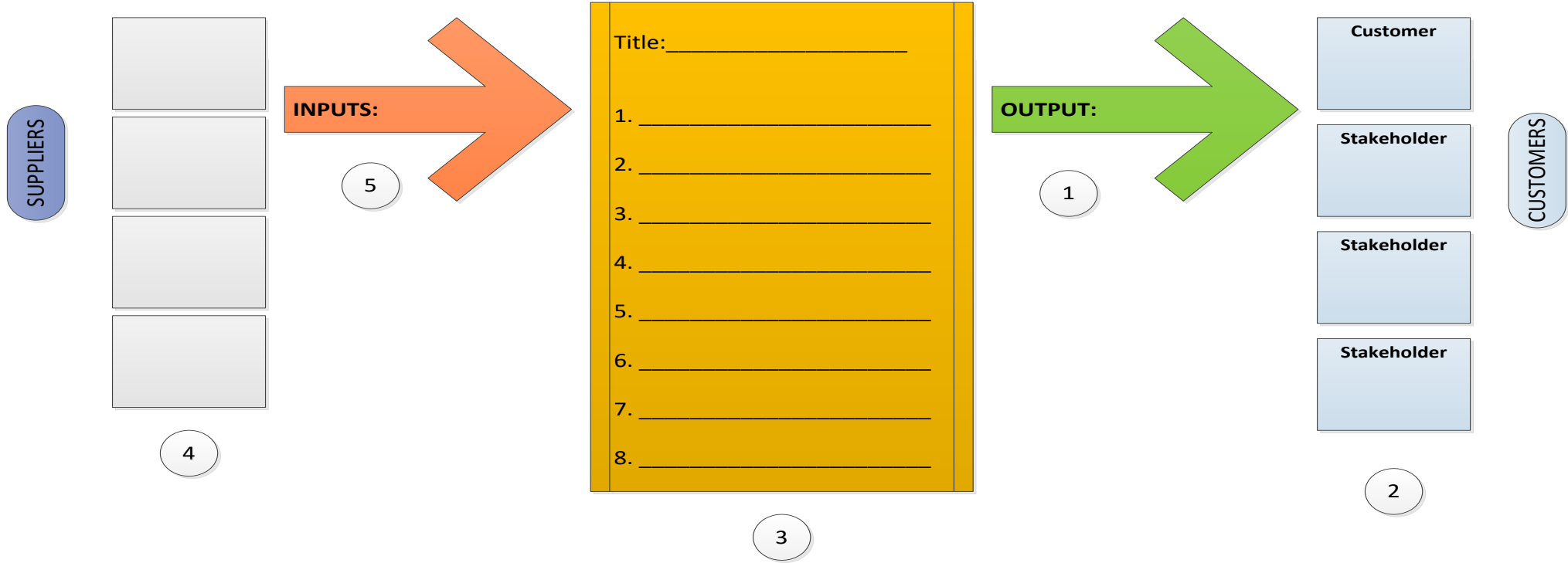
Staff not communicating with each other and patients

Providers being upset at staff

Long wait times in reception area

Patients waiting to check-out

ACS Sample SIPOC



Suppliers

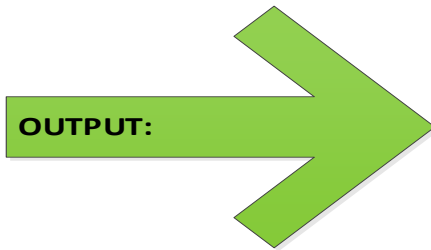
Inputs

Process

Output

Customers

1



What product, process, procedure, policy, improvement or new entity does this team want to produce. State it here as the OUTPUT. 5 words or less.

2

Customers

Who is going to receive and benefit from the OUTPUT the team desires to produce. The primary beneficiary of the OUTPUT is the CUSTOMER. Other, secondary or adjunct interested parties are STAKEHOLDERS. List all that apply.

3

Process

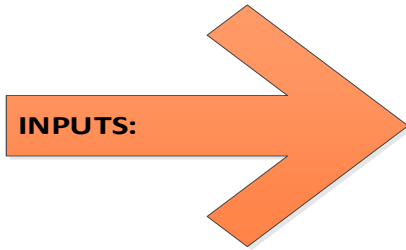
Imagine how the OUTPUT is to be produced. What are the 10 – 12 MAJOR steps or activities that need to be performed, in order to create the desired OUTCOME? List them here. This is the High Level Process that either exists, or will exist. Functional Workflows will develop this process in more detail. State your Process steps using a Verb/Noun two word descriptor.

4

Suppliers

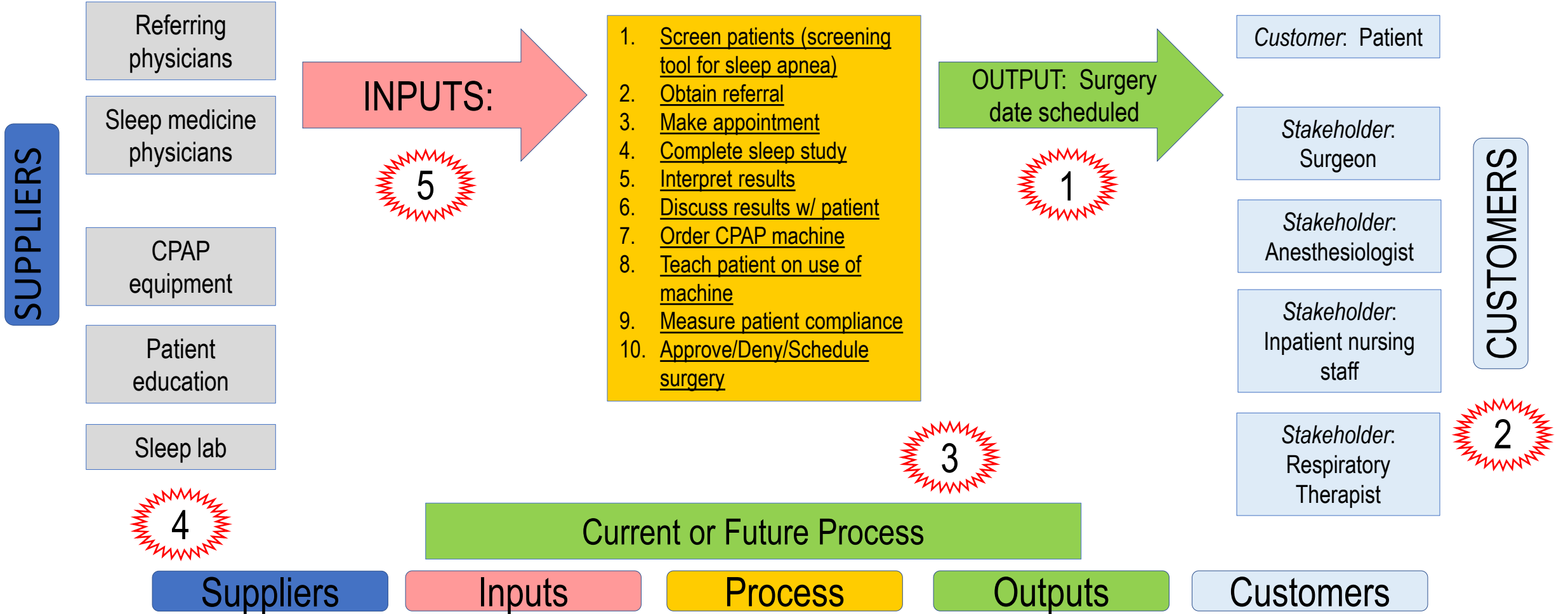
In order to accomplish the 10 – 12 Process Steps: Who will supply the items described in your Process? Who will provide the Labor, Equipment, Facility, Materials, Components or Environment for your Process steps to convert, to achieve the desired Output. These are the required SUPPLIERS for the PROCESS

5



INPUTS are the specific items the Suppliers provide to the Process, for the Process to work effectively. Sometimes identifying the Suppliers is enough detail. If more detail is desired, you can individually state for each supplier, the specific contribution. State what makes sense or leave blank.

Sample SIPOC: 100 % patient compliance w/ preoperative CPAP and BIPAP use



5 Whys (*Analyze Phase of DMAIC*)

Do the following steps to find the Root Cause:

1. State the main cause
2. Ask WHY the main cause happens
3. Ask WHY the cause in #2 happens
4. Ask WHY the cause in #3 happens = Root Cause

5 Whys Example

Problem: Post-operative UTIs in 20 patients within 30 days of surgery.

Main Cause: Foleys were placed in the OR in each of these patients.

Why? This is the surgeon's preference.

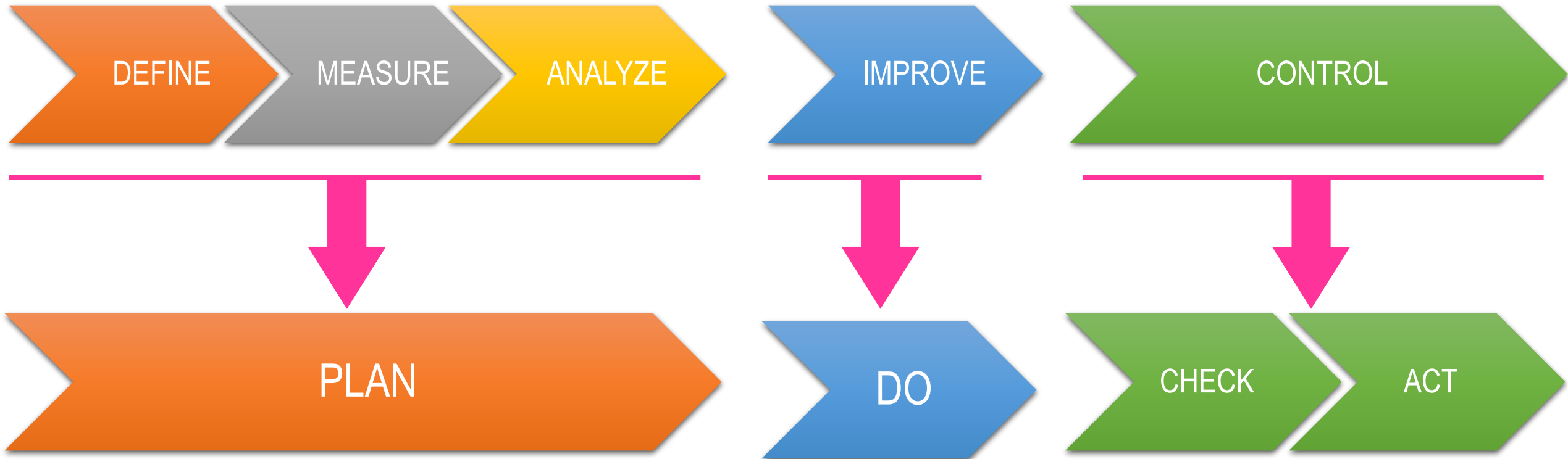
Why? Because the surgeons are worried about urinary retention during the case.

Why? Urinary retention causes pain for the patients & potentially occludes the operative field, in addition, patients often have trouble urinating after general anesthesia.

 **Root Cause**

Process Improvement Comparison

DMAIC vs PDCA



Implement Intervention and Monitor Data

- Communicate, communicate, COMMUNICATE!
- MBS Director gathers all stakeholders to ensure engagement and buy-in
- Intervention must be clearly defined and implemented consistently
- Data must be monitored closely and often.
 - ✓ If desired outcomes are not achieved, adjustments to the protocol should be made

QI Wrap - Up

6. Present Study Results

- Gather all documentation and data for presentation to the MBS Committee at the annual QI Meeting (see Standard 2.4 for details); compare your data with current national benchmark data if available
- Review lessons learned, ways to sustain improvement, etc.
- Keep all records and documentation on file for your next triennial MBSAQIP Site Visit

CELEBRATE your efforts and your successes!



Remember!

1. QI Projects must be led by the **MBS DIRECTOR** and engage all members of the MBS Committee
2. Accredited centers must implement a **NEW** QI project every year
3. QI Projects are **DYNAMIC** and must be monitored over the course of the year
4. QI Projects must address a **PROBLEM**

Remember!

5. QI Projects must be **DATA-DRIVEN**
6. Once you begin receiving Semiannual Risk-adjusted Reports (SARs), your center must prioritize QI related to models where the center is found to be a **HIGH OUTLIER** (see Standard 7.2 for complete details)

Reminder!

IMPORTANT NOTE: Identifying a good QI initiative may require reviewing multiple different topics in order to identify the one most appropriate for your program

QI Ideas from the “Trenches”

- Project to increase PO protein intake at 30-day post-operative visit
- Project to increase attendance at support groups
- Project(s) to increase long-term follow-up (LTFU) compliance
- Project to ensure lab results obtained prior to LTFU appointments with MBS Team members
- Project to decrease patient waiting times in MBS Clinic

QI Ideas from the “Trenches”

- Project to increase patient adherence to post-operative exercise regimen
- Project to identify thorough pre-operative patient work-up/evaluations
- Project to increase patient compliance with preoperative CPAP use
- Project to increase PO hydration the first 30-days after surgery

Additional Resources:

<http://www.health.state.mn.us/qi/>

MDH Minnesota Department of Health

HOME TOPICS ABOUT US

QI and Performance Management

Quality Improvement and Performance Management

Public Health & QI Toolbox

Customer Focus

More QI Resources

Related Topics


LPH Assessment and Planning: QI Plans

Public Health Core Competencies


Accreditation

QI Training and Webinars

Health Partnerships Division

Emergency Prep. and Response 

Public Health Practice Section

Health Partnerships Division 

Quality Improvement and Performance Management

On This Page

[What are QI and Performance Management?](#)

[QI Processes and Tools \(Public Health & QI Toolbox\)](#)

[QI Projects](#)

[Customer Focus](#)

[QI Training and Webinars](#)

[More QI Resources](#)

You Might Also Like...

[LPH Assessment and Planning Process: QI Plans](#)

[Public Health Core Competencies](#)

[Accreditation](#)

Need Technical Assistance?

The Public Health Practice Section can help: [Help and Technical Assistance Available to Local and Tribal Public Health.](#)

What are QI and Performance Management?

Quality Improvement (QI) is the use of a deliberate and defined improvement process and the continuous and ongoing effort to achieve measurable improvements in the efficiency, effectiveness, performance, accountability, outcomes, and other indicators of quality that improve the health of the

 Share This

How are we doing?

Please provide feedback!

Contact the PH Practice Section

health.ophp@state.mn.us

Phone: 651-201-3880

Staff Contact Information

Most Requested: PH Practice Section

Get Help and Technical Assistance

Contact Local Public Health

Find Your Public Health Nurse Consultant

CHS Mailbag & Calendar

Training & Webinars

LPH Assessment and Planning Process and Deliverables

Public Health & QI Toolbox

Annual Reporting (PPMRS)

SCHSAC

Quality Improvement Toolkits

- 30-Day Readmission, Surgical Site Infection (SSI) and Urinary Tract Infection (UTI)
- Resource Portal

QI Tools

Surgeon NPI
National Provider Identifier

Quality and Safety Conference Presentations

30 Day Readmission Toolkit

Surgical Site Infection (SSI) Toolkit


Case Data Validation Tool

Urinary Tract Infection (UTI) Toolkit

- ✓ Toolkit Overview
- ✓ Video
- ✓ PowerPoint Presentation
- ✓ Case Study
- ✓ Visual Abstract

Quality Improvement Toolkits


- Toolkit elements:
 - ✓ Educational video
 - ✓ PowerPoint presentation
 - ✓ Case study
 - ✓ Visual abstract
 - ✓ Additional resources



30-Day Readmission Bundle Summary


<p>1 Preoperative</p> <ul style="list-style-type: none"> Postoperative prescriptions Prescheduled postoperative visit with attending surgeon Patient education video modules 	<p>2 Perioperative</p> <ul style="list-style-type: none"> Discharge checklist Nutritional consult with Registered Dietitian Standardized order set Distribution of Help Card
<p>3 Postoperative</p> <ul style="list-style-type: none"> Discharge phone call within 24-48 hours of patient discharge Postoperative visit with surgeon and Registered Dietitian within 30 days of surgical procedure 	<p>4 Data Registry</p> <ul style="list-style-type: none"> Monthly readmissions review with the MBS Director, MBS Coordinator & MBS CR Root cause analysis for all readmissions

For questions, email mbsaqipquality@facs.org



Surgical Site Infection (SSI) Toolkit Summary

<p>1 Smoking Cessation</p> <ul style="list-style-type: none"> Interventions such as patient education, coaching, and nicotine medications for current smokers as early as possible following decision to schedule surgery 	<p>2 Glucose Control</p> <ul style="list-style-type: none"> Target blood glucose levels of 110-150 mg/dl suggested Interventions should be started as early as possible Important for patients diagnosed with diabetes 	<p>3 Preoperative Bathing</p> <ul style="list-style-type: none"> Chlorhexidine bathing as part of an institutional SSI prevention bundle reduces SSI risk.
<p>4 Skin Preparation</p> <ul style="list-style-type: none"> Use alcohol-based solutions Remove hair if necessary only with clippers as close to prep time as possible Do not shave the surgical site abdomen in the preoperative area or the OR 	<p>5 Prophylactic Antibiotics</p> <ul style="list-style-type: none"> Administered within one hour of incision Weight-adjusted dosing recommended Choice of prophylactic antibiotic based on surgical procedure and the anticipated pathogens 	<p>6 Limited OR</p> <ul style="list-style-type: none"> Minimize traffic in operating room



Urinary Tract Infection (UTI) Toolkit Summary

<p>1 Patient Considerations</p> <ul style="list-style-type: none"> Perform urine analysis on high-risk patients Place drainage bag below the level of the bladder Systemic antimicrobial treatment at the time of bladder catheter removal is <u>not</u> recommended 	<p>2 Urinary Catheter Considerations</p> <ul style="list-style-type: none"> Urinary catheters should be placed only when medically necessary Indwelling catheters should be removed as soon as the indication for insertion has been resolved Nurse-based and/or electronic reminder systems to inform caregivers of need to consider catheter removal Automatic stop-orders are recommended to limit catheter use duration 	<p>3 Staff Training & Education</p> <ul style="list-style-type: none"> Department-level education efforts to acquaint staff with indications and contraindications for catheter use Education efforts to inform staff of the benefits of limiting the duration of catheter use Standardized training on sterile technique with placement of Foley catheters Aseptic technique for maintenance of indwelling bladder catheters
--	--	--

Closing Reminders

- QI Projects must address a **PROBLEM** (if you don't have any SSIs in your sleeve patients, then don't choose this as your project)
- QI Projects must be **DATA-DRIVEN**--develop a metric to measure the effectiveness of your QI project and identify the baseline

What Not to Do....

- Do not conduct a QI Initiative on a “hunch”





MBSAQIP[®]
METABOLIC AND BARIATRIC SURGERY
ACCREDITATION AND QUALITY IMPROVEMENT PROGRAM

A QUALITY PROGRAM
of the AMERICAN COLLEGE
OF SURGEONS

Website: www.facs.org/mbsaqip

Email: mbsaqipquality@facs.org

Phone: 312-202-5565