AHRQ Safety Program for Intensive Care Units: Preventing CLABSI and CAUTI

Transcript

How To Address Attitudes and Beliefs Around Infection Prevention Strategies and Techniques

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[*Opening music*]

Kate Schmidgall: This audio interview is a production of the Agency for Healthcare Research and Quality and is part of its toolkit for the Comprehensive Unit-based Safety Program, or CUSP, for intensive care units. I'm Kate Schmidgall and I'm joined here by David Thompson, Associate Professor of Anesthesiology and Critical Care Medicine at the Johns Hopkins University School of Medicine.

He serves as Director of Patient Safety Education for the department and holds a dual appointment at the Bloomberg School of Public Health and the Department of Health Policy and Management and in the school of nursing in the Division of Acute and Chronic Care.

Today, we're discussing how to address attitudes and beliefs around infection prevention strategies and techniques. David, welcome.

David Thompson: Thank you very much.

Kate: So, one important way to reduce catheter-associated urinary tract infections, or CAUTI, is to decrease the use of indwelling urinary catheters both by avoiding catheter placement when clinical criteria are not met and by removing the catheter when it's no longer necessary. But some challenges, particularly in ICUs, involve attitudes and beliefs about the need for monitoring hourly urine

output, for example. How would a team work to address those attitudes and beliefs?

David: So, attitudes and beliefs are framed by the environment that we

work in or the culture. If you were an organizational psychologist or industrial psychologist, they'd say culture is the way we do things around here. So, just because you have a wonderful organization doesn't mean that your culture is one where you are ready to implement new programs or you're changing a chain of thought.

And what I often say is to get one clinical provider working with one nurse to follow a small group of patients and to see whether or not you can go ahead and pull that Foley or prevent that Foley from being placed. Where we come in, attitudes and beliefs I think that have a significant impact, are what our patients and our families tell us. And that is that, "Oh, my father looks too tired to get out of the bed or to use a urinal or — and they want the Foley left in to make it easy for their hospitalization. We have a big job ahead of us, and we've been doing this for a long time, but it's to educate the patient and the family.

To say that these attitudes and beliefs that we have, that everybody is always going to do the right thing, can't hold true if you have a change in staff, if you have a change in administrator, who may not be informed about what the current policies and procedures are.

And so, we really have to go back in and keep a check on our self, because there are a lot of competing priorities out there. And if you're trying to work on every hospital-acquired infection prevention program, maybe something has slipped. And you really need to go back in and audit, identify what you need to fix, and go back in and retrain and re-educate.

Kate: So, the audit, you mention that as keeping a watchful eye. Do you think that's regular practice in some of the ICUs that might have stubborn infection rates? Or is this a new idea that we might need to prompt continued consideration for?

David: I think we may need to prompt continued vigilance as far as this goes. If you have a high infection rate, then you might want to do more than a 10 percent sample. You might sample 50 percent of the patients, just to see — or 50 percent of the patients that have a Foley catheter to see what they've done.

We also work with Infectious Disease. And they come in and they assess, in addition. So, we might have a nurse manager who assigns a senior clinical nurse to audit that 20 percent sample, and then we compare that to a sample done by our Infectious Disease. I was at a large academic center, and they said, we have 75 percent compliance with hand hygiene. And when we came in from an outside hospital, they knew we were visitors but they didn't know what we were there for, and what we saw was 10 percent compliance with hand hygiene. So, getting somebody that people are not familiar with to come in, to walk in — don't announce that they're coming; don't let them know what you're there for — it really is quite eye opening to see.

There are plenty of tools out there, all ready to develop, and all it takes is for somebody to get started, to say that this is part of our new program. And whether you do it, I think, at least once a week, when you have stubborn infections, or your infection rate is high. And then, as you get better, you can reduce your sample size, and you can also reduce the frequency that you do them. But it really does tell you a lot about what's been going on in your unit. Because we always think, our attitudes are, we're there to help people, but sometimes we miss things.

One of things that I recommend is that we train physicians and nurses together so that the physicians don't get something said to them one way, the nurses get something said that leaves to a subject of interpretation.

Kate: And I imagine that it helps to build cooperation, trust, mutual respect, and all of those things have a big role to play when you're talking about creating a safe culture.

David: Yes. I can remember a physician telling me, “I don't see why I have to know how to change the central line dressing or even how to put one on.” And I said, if it's a really busy day and the nurse is there to help you with the placement, don't you think you should know how to put the dressing on? What if the nurse has to step aside to her other patient? And they said, “OK, that makes a good point.”

And so, if they don't know, it really, it's doing a disservice, not only to them, but especially to our patients, because we're there to prevent patient harm.

Kate: And that also helps to break down hierarchy.

David: And that is the goal. I mean, you have a much more functional team when there's less hierarchy. Yes, there are people that lead an organization, but with the CUSP program, you have senior executives who might be the dean of the

school of medicine that work with you very closely. You're calling them by their first name.

And it really does change that perception. So, people that you might not have ever met in your career before are now actually on the frontlines with you and seeing what you go through, whether they're a clinician or not. And I think many of them are amazed at the working conditions that we have and just what the — how fast the pace is for doing these things. It really changes that whole dynamic.

Kate: And that first-name basis is an indicator of a strong safe culture, where people are empowered to speak up and share knowledge and information.

David: It is. In fact, we did — there was a campaign in one of the ORs led by a surgeon, and it was Names First. And his point was, if in a critical situation, you needed, let's say a chest tube, a 32 chest tube, and you said, somebody get me a chest tube, because the patient had pneumothorax or something. And he goes, if I just say, get me a 32 chest tube, and I didn't say it to anybody in particular, how quickly is that chest tube going to be there? Everybody's going to look at everybody wondering where that tube is coming from. But if I say, Mary, can you get me that chest tube, so Names First was very important.

Kate: It also seems like it's just a very natural reflection of that breakdown of the silo between physicians learning one thing, nurses learning another thing. Now you're on a first-name basis. A very clear partnership in that process.

David: It is. And I think for physicians, I think the worry at first was that there would be — it would be uncomfortable for patients to hear them called by their first name. So, what we did was, we said, in front of the patient you're still Dr. Miller or Dr. Whoever, but when it's just us, you're Mike. I'm David. This is how we do things. And it works out so much better. And I think it really has brought us closer. And all the research shows that the better you know somebody, the more familiar you are with them, the better you can anticipate their needs. And that also does a lot to prevent adverse events and to mitigate patient harm. So, definitely one of the most worthwhile things we can do is to get people to know who they work with and use their first names.

Kate: Let’s stay on adverse events for a second. Talk to me about learning from defects, like mini root cause analysis, and anything that might be useful here when we're talking about changing attitudes and beliefs. Knowing when, even,

that we need to change attitudes and beliefs, for example, or how that might have played a part in an adverse event.

David: So, I'm a CUSP senior executive for a pediatric unit, and it was like pulling teeth to get them to do learning from defects. And the reason was, is they thought based on their experience they could identify the single root cause. But when we actually had them work through the whole learning from defects — so we stood up there and we did the learning from defects or the mini root cause and we identified all the system factors. And so, it wasn't just the fact that we were trying to save money and we didn't have enough labels, so that's why the specimen was mislabeled. There were lots of reasons why. And I think that that's really important. It identifies the system factors that were responsible. It also identifies the system factors that help prevent harm.

Some people don't like saying system factors because we're dealing with people, but you have to remember that two of the system factors, some of the system factors that we look at aren't just our equipment, or do we have adequate lighting to do the work that we need to do. But they're team behaviors. So, did I seek supervision when I should have? Or as, if I'm an attending physician, did I offer supervision when something was happening?

But there's also provider behaviors. Was the provider ill? Was the provider adequately trained? So, rather than say, this provider made a mistake, it's this provider was inadequately trained.

But those team behaviors and the provider behaviors. And those are really opportunities for us to begin to look to see how we can train our workforce to better meet the needs of our patients.

It used to be, you fill out an adverse event report, it went to the nurse manager, it went to risk management, and the frontline staff got no feedback. When you have a CUSP team with the LFD tool, it not only goes back to the frontline staff, there's an announcement of, so this is what we found, and this is what we're going to do, and everybody is then informed. So, it's based on a really rigorous way to identify the problems that we had that caused the defect and what we're going to do about it.

The other thing is, is that, when you use the learning from defects, as I said, it identifies things that limited the potential harm. So, that's one of your first strategies is to take one of those things and automatically include that into a policy and procedures.

Kate: And it sounds like, when we talk about how to change attitudes, it really comes down to regular evaluation and routine communication that brings, sort of, the behind the scenes to the forefront and allows the whole team to see what's going on and where the breakdowns might be happening.

David: Yeah, and a good example of that is that when a nurse gets their yearly evaluation, often it will have their work in quality and safety and things that they've done to improve the patient experience or how they've improved patient-centered care. The difference with physicians is, in many organizations, we do not have that on their yearly evaluation. Have they worked in quality and safety, or what have they done? And, at least at our organization, we have a mock program where they can, if they're on a CUSP team, for instance, and they've tackled several really big adverse events, that they do get credit for that. So, that is on their evaluations.

Kate: What would you say to someone, if I were a nurse, for example, or just a frontline provider at an ICU with a stubborn infection rate, and it just seemed like the team did not believe that getting to zero was possible?

David: So, I have a great story. We took the CLABSI toolkit to Spain. And we had a physician who was probably in his 60s pilot the program. And the first thing he said to us, "When I was being trained, it was not unusual for us to expect this many infections, this many central line infections, and this many people to have sepsis, and this many people to die." And he said, "And yet, I followed the bundle, and now I'm getting ready to implement the CAUTI bundle. And, guess what, I'm down to one infection. One infection for the whole year. Isn't this pretty amazing?" So, it can happen. And it does happen.

And there's plenty in the literature. There's the first study that was done in Michigan, and then there have been many studies thereafter. And there are tools that we have developed in the CUSP program that help us to get there, that improve teamwork, improve communication, that all show that this can happen. We have teams celebrate their successes. And we've had some units, at least within Johns Hopkins, that have gone several years without an infection, whether it be CLABSI, a CAUTI, a VAP, whatever. So, we know it can happen.

What we've found is that we're working with a very well-educated but extremely busy group of people. And often, it takes us printing out the article, writing a little fact sheet, this is the latest literature review, and this is what we found. And then we have some how-to points. This is how you implement. This is how you maintain. And I think that they're very surprised. In fact, we had to

do that with every infection control bundle that we did because there was always the dissenter, always the naysayer that said this is impossible. I've had a medical director of the medical ICU at one hospital say, “I'm happy that we're down to six infections per month.” That's horrifying to me. And I say, what is your baseline? He says, we have a really sick population, and our length of stay is 23 days. And they got down to zero. So, to share successes like that, yes, it does happen.

We can definitely get to zero, because we have.

[*Closing music*]

Kate: Thank you, David, for joining me today.

David: And thank you for having me.

Kate: This has been a production of the Agency for Healthcare Research and Quality, part of the U.S. Department of Health and Human Services. Special thanks to David Thompson for joining us today. To learn more about safety issues in ICUs and CUSP in general, visit AHRQ.gov/hai.

[*End of recording*]

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