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

Transcript

How To Have Difficult Conversations With Colleagues Around Infection Prevention Practices

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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 by Pat Posa, registered nurse, quality excellence leader at St. Joseph Mercy Health System.

Today, we're discussing how to have difficult conversations with colleagues around infection prevention practices. Pat, welcome.

Pat Posa: Thanks, Kate. Glad to be here.

Kate: Let's start at the beginning. How do we do this well so that a strong culture of safety is built?

Pat: So, as you're trying to improve communication and, in essence, your safety culture and preventing patient errors, the first step is really about setting expectations that communications will happen.

You would then need to choose what tools are you going to use to improve communication, and then educate people on those tools allowing, just like you would educate on a new procedure or a new drug that came out or a new way

to care for the patient with adult respiratory distress syndrome. This would be, we have a specific way we want people to communicate to make it easy to speak up. We want you to use these tools.

Kate: And then practice, right?

Pat: And then you need practice. So, you would practice in a classroom setting as you're learning the tools, but then you need to be able to practice at any point in time. Just like with anything else, you want champions. You want to have people on your unit that are very comfortable that other people can go to. But in key, your leadership needs to be experts on this because they're the ones that can see where the conversations should have happened and didn't, and help mentor and coach in the moment and then after the moment.

The times to practice, you can use structured time that's already set in your typical environment, so structured times. Like in the nursing world, it's in nursing practice council, where they can role-play situations that happen on the unit peer to peer, physician to nurse, respiratory therapist to nurse, and use real examples and apply that framework that you've chosen to use, and have them practice and role-play and give them feedback on how it went.

Kate: Which specific prevention practices tend to prompt or require confrontation?

Pat: Well, I don't know if I would qualify it as confrontation, but probably more intervention. So, frequently, probably one of the more concerning ones where you would want to act right away would be a break in sterile technique during putting in a central line or not properly adhering to best practices during putting in a central line. Other prevention practices that require a conversation might not be as acute would be compliance with using personal protective equipment, hand-washing, items like that.

Kate: In the moment, why is it difficult to speak up, do you think, in some of these ICU environments? What might be the factors at play?

Pat: Well, there are number of factors. One is, traditionally, we have hierarchical cultures. And so, it depends on when you're talking about a break in sterile technique in a central line, it's usually a physician that's inserting that central line. It would be a nurse that would be observing that. And that hierarchical culture isn't always open for dialogue and feedback traditionally. But that has changed. But if you're in a unit where there is still that culture that what the doc does or says goes without questioning being allowed, then, it would be very difficult for a nurse or others to speak up.

Kate: How do we begin to coach nurses through that moment? What are some things that they could keep in mind or even cultural changes that you have seen?

Pat: You really do have to back up and get some cultural changes because the nurse is not going to speak up if they believe, or their past experience, have shown negative consequences to that. So, if I've said something before and then I've been pulled into the office or if I heard someone else say something and that was that consequence, then no one's going to speak up.

In speaking to the physician, in the moment, you would just use very technical, objective language. “Dr. So-And-So, the guidewire touched the headboard. Here, let me get you another sterile guide wire.”

So, it's really about creating an expectation upfront, prevents having a lot of misunderstandings in the moment. And so whatever you can do to create and standardize that expectation upfront, will make that communication easier. And that becomes a support then for the nurse.

Kate: Exactly. In part, how to have a difficult conversation is to set an expectation for a conversation in the first place.

Pat: Correct.

By establishing a process that prior to a central line insertion, we do a preprocedure briefing where that standardized, that preprocedure briefing, reviews what the best practice is, reviews what the nurse's role is during the line insertion, and it calls out if there is a breach, the nurse will then ask, "Well, how would you like me to let you know if I notice one of these things?"

So, then now you're having a conversation. It's setting expectations, allowing that physician to decide how he or she wants to be told if there's a breach, knowing that maybe you have an awake patient that might hear the conversation. And so, you want to be respectful of that. Very important to set that expectation.

So, the physicians have to be on board. You have to work through the medical staff to your local medical staff. But in the instance of the central line insertion process change at our organization, we ensured that the chief of medicine and chief of surgery were on board, understood the change in practice, supported the change in practice, and supported that the nurse will speak up if the best practice isn’t being followed or if there's a breach in sterile technique, and they endorsed it. They endorsed it to their section heads. And then it trickled down.

Sharing that with the nurse that support had been provided and encouraged, that empowered them to feel comfortable then speaking up. And so everyone then is on the same page. The nurse knows the doc is on the same page. They're supporting it or at least the physician leadership is supporting it. It might not have trickled down all the way to this person. So, you clarify it at that moment.

One of the things that we have also considered and have added to our pre-procedure briefing is having a conversation of when is the best time to insert this line because if it's an emergency, it's an emergency. It's all hands on deck if it needs to go in right away. But oftentimes, it can be scheduled for an hour from now, a half hour from now, two hours from now.

So, it's important to agree upon a time because, then, that nurse can be fully present to be able to ensure that the line goes in without a hitch, without any breaches, and that the best practices are maintained.

Kate: It could be a really good idea if you're in an ICU with a stubborn infection rate to consider those preprocedure briefings incorporating the roles and responsibilities so that we set an expectation for a conversation beforehand.

Pat: Yeah, I'm going to take out the defensiveness by setting up that expectation that this is going to happen. Then, the receiver of the information is going to be — is less likely to be defensive if we've set up that expectation. OK, I know. That's what you're going to do. I've told you this is how I want you to tell me, and that's how you're telling me. Then I have no reason to become defensive.

Kate: Let's move to another scenario. Let's say it's a peer-to-peer conversation, and you notice a peer nurse enter a room without washing their hands or for any number of reasons. Break that scenario down for me. Why might it be happening, and how would you coach me to have that conversation?

Pat: Some of it can be understanding of when I need to do it. I think people understand why it's important, but the biggest factor, I think, is just forgetting it. It hasn't become a habit, and part of the strategies an organization can take to help it become a habit is to make it easy to do the right thing. So, if I'm walking into the room and you want me to wash in, wash out, then I have to have the tools to be able to do that.

And they have to be convenient. If I'm going to use an alcohol dispenser, then it has to be full, and it has to be located where I'm going to come into the room. It can't be every other room because every other room's not going to help me. It

needs to be every room. The sink needs to be at a location that's easy, and it needs to be functional, and it needs not to splash on my paperwork.

And so, those structural things need to be put in place so that it's easy then for any health care provider to perform the tasks that they need to.

And make sure you understand not their side of the story, but it's their side of the story, that you listen to — maybe you didn't observe them. For example, you didn't notice them use the alcohol, but they went in and they did use the sink, and you didn't see that. You just saw them. So, when you're providing that feedback, you need to use tools where you're starting off just sharing the fact. "Hey, I noticed when you went into room 21, I didn't see you wash your hands. And I know you know that's important, and you know it's all about infection prevention, and did I miss something?"

You're making sure that you heard the whole story.

And without that listening, if you just, "hey, you didn't wash your hands," then you're not going to hear what might have been their barrier.

Kate: Right. Building that safe culture.

Pat: Yeah, and respect and preventing defensiveness. But in it, if you truly want people to give feedback on handwashing and everything, you have to set the tone in that unit as part of the culture is that we expect you to hold yourself accountable, but hold each other accountable. And that has to be supported from leadership and peer groups. And then when feedback is given, it should be received with, thanks for sharing that with me.

Probably, the biggest pitfall is not having the conversation, right? And that's probably what most frequently happens: "It's not my job. They're professionals. They should know." So, a big part is not taking ownership that it is because it's about the patient, and we're a team, and we have to hold each other accountable.

Kate: Which requires that change of culture so that everyone is expected to observe and also to speak — frankly, objectively, honestly.

Pat: Respectfully. And that's probably the other opportunity or the biggest faux pas is in those conversations, they're not always doing it with respect. And it's because we haven't provided them with the right tools. These are hard. How do

you start the conversation? How do you bring it up? What are the rules? And so, there are frameworks out there. There are tools out there.

Kate: I think that's probably a really important note for many ICUs that might not have a practice rhythm for this particular topic on how to have difficult conversations. So, simulations or role-playing could be really valuable.

Pat: And we don't allow ourselves enough time to practice those skills as a nurse at the bedside or a physician. You have to go through mandatory training on using the equipment and all these other things, but not to practice how to communicate. And we need to. We need to have that same emphasis on rehearsing and practicing how to communicate.

A lot of organizations in the nursing realm will have unit-based nursing practice councils. And those are part of a shared governance structure so that the frontline staff play a significant role in defining the practice in that unit. And we've used that forum to practice real-life scenarios that we'll hear feedback of tensions between the nurses and the residents. And so, we'll take that actual scenario, and then we'll say, "OK, we're going to role-play this. We give them a framework to use, so from TeamSTEPPS, you could use the DESC Script framework and have them role-play it. They did it with a buddy — "You be the resident, I'll be the nurse" — and they went through it, and then they switched roles, and then they debriefed after it. We had someone sitting observing that conversation. And then they debriefed, and then we debriefed as a group. But it gave them some tools. They were actually — afterwards, part of the feedback that we got is you can think you know what to say, but putting the words together is so different, and having practice putting those words together was very valuable.

The unit has to set the tone, or it has to be an expectation in the unit that conversations will happen. It's important that the expectations are set, but then you also have to provide the staff with the tools to be able to have those conversations. So, you have to create the environment that says we expect those conversations, those conversations are good, and then you have to back them up. When those conversations happen and someone comes and complains that the conversation happens, you have to listen and support that this conversation needed to happen. Maybe there's improvement in how it happened, but the essence of the conversation was important.

Kate: When people speak up or when peer-to-peer conversations happen, we need to acknowledge that this is a good thing. It's healthy for the unit, and it orients us toward our common goal of zero infections.

Pat: Absolutely. When people speak up and it's followed with support, approval, or celebration of that speaking up, that helps ingrain the culture that speaking up is good.

[*Closing music*]

Kate: Thanks, Pat, for joining me today to talk about how to have difficult conversations.

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 Pat Posa for joining us today. To learn more about safety issues in ICUs and CUSP in general, visit ahrq.gov/hai.

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