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

Transcript

How To Increase Ownership and Engagement at Multiple Levels To Prevent Infections in ICUs

Host:

Kate Schmidgall

Interviewee:

Anne Donovan, M.D.
Assistant Clinical Professor
Associate Program Director, Anesthesia Critical Care Fellowship Program
Departments of Anesthesia and Critical Care Medicine
University of California, San Francisco
San Francisco, CA

[*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 Anne Donovan, assistant clinical professor of anesthesia and critical care medicine at the University of California, San Francisco.

Today we're discussing prevention of healthcare-associated infections in hospital intensive care units, and how to increase ownership and engagement among frontline staff, physicians, and hospital leadership. Anne, welcome.

Anne Donovan: Thank you.

Kate: Let's assume that an ICU has been trying to implement infection prevention efforts for a while, but the new initiatives are creating only limited success. How can the efforts get a reboot, to get the ICU team focused on working towards the goal of zero infections?

Anne: I think it's really important to make sure that what you're doing is really visible. So, one of the things that I notice is that people have a lot on their minds. There's a lot of quality improvement initiatives, there's a lot of best practices,

and you want to make sure that what's entailed in your protocol is not just getting lost in the shuffle. So, you can't expect to present this new initiative once, and then expect it to be widely adopted. So, you need to really be repetitive, make the efforts visible, and keep reminding people that this is a common goal that we're all shooting for.

Kate: How do you make things visible?

Anne: There's a lot of different ways to make things visible. I think, in general, a lot of people respond well to data, like infection rates, line days, catheter days, number of patients in a unit with lines at this time. So, first of all I think you have to collect that data. Second of all, there are ways to display that data, or even just to talk about it. So, you could create bulletin boards displaying those data, you could email fliers or posters, or you could integrate it into the daily handoff or huddle process, so that you're talking about it on a daily basis and that people are hearing it discussed over and over again.

What might be interesting to staff during a daily huddle would be things like number of patients in the ICU right now with central lines or with Foley catheters, with a reminder that part of our quality improvement project is to try to remove those lines, and encourage staff to think about, do patients still need those lines? And if they don't, maybe discuss with whoever is in charge of deciding whether or not that line still remains in place.

Anytime you can incorporate real examples of how either something that you did actually went on to affect a patient and improve an outcome, or, if something was missed or something wasn't done the way that it should have and perhaps contributed to harm, anytime you can see a real impact of an intervention on a specific patient, I think that's a really powerful way to convey the message that we're all in it together, and these interventions really do make a difference for individual patients.

I think in general we all want to help patients. And so, demonstrating the impact of our practices on real people I think can have a profound impact on building engagement and making people feel that they are part of potentially the problem and the solution.

Kate: Let's talk more about engagement. How can an ICU team engage or re-engage people in efforts to reduce healthcare-associated infections?

Anne: I think, again, trying to re-engage champions.

It's also important to seek feedback from the people in the unit about maybe why it's not working anymore. Maybe it's too hard for their workflow, maybe they don't have time to do it, maybe there's a simple fix that could improve compliance.

Frontline staff often think of things, or see things, or experience things that you may not have anticipated when you were creating a protocol. So, it's really important to go back to the people who are actually carrying it out, and try to get their feedback about what's working and what's not, and then actually act on anything actionable that they bring up so that they can see that you're listening to them.

I would start there. I would also think about setting some kind of goal that is measurable and achievable, and perhaps thinking about incentivizing achieving that goal. You could do anything from a monthly lunch for the staff if you achieve your desired CLABSI or CAUTI rate for the month, or — I mean, in general, food is a good motivator. So, a lot of the ideas I have, or the things I've seen done revolve around—

Kate: Chocolate.

Anne: Yeah, exactly, but at the same time you want your incentive to be something that's actually going to motivate people. So, if you're able to have financial incentives, some places have sort of a yearly unit-based financial incentive goal. So, if you can try to incorporate your project into some kind of an incentive plan for people, to give them a reason to want to do it beyond just doing what's right for the patient.

Kate: Whose job is it to ask, is this catheter still needed?

Anne: It's everyone's job. Anyone who has direct contact with the patient can ask that question. So, nurses are with the patient for hours a day. They should be thinking about whether the lines or catheters are needed every single shift. Physicians or advanced-practice providers should be thinking about this at least daily, if not more often than that. Physical therapists and occupational therapists have an opportunity to think about lines and tubes that are interfering with their ability to do their work, and whether those lines and tubes are still necessary. And even other providers that I didn't mention are also involved. And then finally I would end with the fact that patients and families are also really important in that conversation, too. I've had a lot of patients tell me that their Foley catheter is really uncomfortable, and why can't it come out

right now, and that should be a really powerful trigger to think about whether or not that catheter is still needed.

Kate: Are there other examples you can describe of engaging people in patient safety efforts?

Anne: In our ICU we asked providers of any kind, anybody walking through the ICU, we asked them, "How will the next patient in our ICU be harmed?" And, we asked people to keep an eye out for problems that they saw or things that they encountered on a day-to-day basis that could lead to patient harm. And, when they saw those things, we asked them to write it down, put in a box, and then that box was taken to our CUSP meetings, and we reviewed all of the different ideas that had been submitted by staff. And they were anything from, you know, just very minor, maybe we don't have enough of this particular IV tubing in supply, all the way up to things like, in our code carts we don't have 14-gauge angiocaths to use if a patient has a pneumothorax during a code.

And we tried to brainstorm ways to act on any of the actionable suggestions. And in that way, we actually came with a number of what we called CUSP safety solutions where new equipment, or new workflows, or new supplies, or just new ways of doing things were created in our ICU based on suggestions from frontline providers. And when one of those solutions was created, we made it very visible. So, we gave credit to the person who had submitted the idea in the form of a poster or a flier, gave sort of shoutouts to people who had brought up concerns in staff newsletters and things like that.

That does a couple of different things. Again, it makes your efforts really visible, but it also reinforces and validates the behavior of bringing up safety concerns. So, it promotes a culture of safety for people to speak up when they see something that they think could be harmful. And there are many ways to give credit and to make these types of efforts visible, but just the process or the act of doing that I think can be really validating for staff.

Kate: Also, that's an opportunity to involve new people, right?

Anne: Yeah. It's a great idea. New people who are coming into your unit who maybe come from a place that have done things differently might notice things that you don't notice in the kind of the day-to-day way that you've always done things. So, giving them a way to bring up any concerns that they have based on their different perspective and different background can also be a really effective way to engage people who are new to your unit.

Kate: And leveraging that moment in time to draw out that new insight, which they won't have again.

Anne: Right. It also helps I think sort of orient them to your safety culture as well, so that coming into a new environment, they know that they are encouraged to look for things that could be improved and to speak up when they see something.

Kate: So, how do we increase connection between nurses, like frontline staff, and the leadership?

Anne: In general it's important to engage peer groups or peer champions so that there can be interaction and instruction and engagement on a peer-to-peer level, and not coming from a top-down level. Meaning that people perceive that leadership is imposing something on them, it's important that peers are involved so that people can understand why it's important and who's actually asking them to take on a new challenge or change their practice.

Kate: And what about the hospital leadership? How can we help them build ownership of the changes and engage with the ICU staff?

Anne: Some things I've seen that may work include making rounds with the charge nurse, actually talking at bedside with nurses or other care providers about the impact of their intervention on their day-to-day workflow. I do think that it is a whole team effort, so certainly it's as much the responsibility of the hospital leadership team to provide the necessary support and resources and education as it is for the frontline providers to actually incorporate the changes into their workflow.

So, I think if things start stalling out, I think you need to re-engage all groups who are involved. So, leadership, hospital leadership may need to reinvest more resources to allow people to continue education, or continue collecting data, or figure out how to incentivize compliance. The physicians may need to re-up their discussions about what we're trying to do and how to best do it. The frontline providers, you know, it might be something where you need to start talking about it again at your daily huddle, or you need to send out newsletters or talk about in a staff meeting, or figure out a way to make it visible again, and bring it to the forefront of all of the other things that they're being asked to do.

In all of our efforts we should be trying to bring the patient back into the center of everything that we're doing.

Kate: How can you include patients who are able and their families into the process? Can they help prevent their own infections?

Anne: Patients and families can be integrated into ICU care, and specifically infection control prevention measures in a number of different ways. They can round with ICU teams, they can be involved in helping make goals for the day, and in that capacity they can speak up if they're wondering why a Foley catheter is still in place or why they still need that big central line in their neck. They can help with physical therapy and occupational therapy exercises, and again that might be another time when they can speak up about some of these things. And so, I think that more that we bring the patient and family into the care team and make it clear that they're empowered to be an advocate for themselves, the more likely they will be to speak up when either they see something or they're wondering why we haven't done something that might help prevent an infection.

Kate: Any specific tactics on that note that you maybe have seen work before?

Anne: I think talking through daily goals with patients who are able to communicate and participate, or family members, and creating sort of a daily schedule with things like physical therapy's going to come at this time, we're going to work with occupational therapy at this time, et cetera. Anyway, that specific technique I think could establish a baseline of engaging patients and families in their care in the ICU, and in that way might help empower them to bring up other concerns that they have.

Everyone's an important part of the team, and all of the interactions you have with them should promote the idea that their concerns and questions and ideas are invited and valued, that you welcome them to speak up. It's OK to have differences of opinion or disagreements between members of the care team, but it's important to engage in a conversation about why those differences exist and try to come to common ground if you can.

[*Closing music*]

Kate: Anne, it's been a real pleasure speaking with you today. Thank you for your time. 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 Anne Donovan for joining us today. To learn more about safety issues in ICUs and CUSP in general, visit AHRQ.gov/hai.

[*End of recording*]

[*Recorded in 2018, reviewed in 2022*]

AHRQ Pub. No. 17(22)-0019
April 2022