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

Transcript

How To Create Team Buy-In and Motivation To Get to Zero Infections

Host:

Kate Schmidgall

Interviewee:

Sam Watson, M.S.A., MT(ASCP), CPPS
Senior Vice President of Patient Safety and Quality
Executive Director MHA Keystone Center
Michigan Health and Hospital Association
Okemos, MI

[*Opening music*]

Kate Schmidgall: This audio interview is the 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 here with Sam Watson. Sam is the senior vice president of patient safety and quality and executive director of the Michigan Health and Hospital Association Keystone Center.

Today we're discussing prevention of healthcare-associated infections in hospital intensive care units and how to create team buy-in and motivation to get to zero infections. Sam, welcome.

Sam Watson: Hello.

Kate: So, some CUSP experts have said that ICU teams struggling to overcome stubborn infection rates might have an underlying belief that getting to zero is impossible.

Sam: The perspectives in those units that do struggle with infections is that infections are inevitable. It's just dealing with patients who are sick, they are at risk, and sometimes these things happen. There's also, I would say, the risk for apathy around just, "There's nothing within my control that can be done," instead of

thinking about this from the standpoint of, "There are practices and actions that we take as providers that may put our patients at greater risk."

When we are looking at the practices around preventing CLABSI or preventing urinary tract infections as a result of catheters, this effort around changing practice requires that we're all working towards the same direction. So, if you've been practicing a certain way, I need your agreement to change practice. There's no way of coercing you into doing this. It requires an understanding, and it comes to the why. Why do we make these changes? At the heart of it, keeping our patients safe is the why. That's what they've entrusted us with, their safety. That's what we're here for. And nurses, physicians, respiratory therapists, anyone in health care, we come into this duty of care out of a desire to make people better, to provide better health for them. And the why is there. Sometimes you just need to relate it back to the practices.

Kate: So, this becomes a question of communication, and to communicate the why—

Sam: Communicating the why is, first and foremost, if you look at the core in which the CUSP work is based on, engage, educate, execute, and evaluate, the very first is engage. If you translate that data into not a data point, but a person — "So our infection last month was somebody that we cared for for eight days in this unit. During the course of that time we gave her an infection because our practices were not what they should be. That individual could have been home three days sooner had it not been for the fact that we weren't following the proper protocols to ensure that her care was as safe as it could be."

The data are a representation of the story. Essentially, behind every data point there's a person, or an infection, or whatever. And it's drawing that parallel so that people understand the context or the color of what they're seeing of the data. Likewise, the old saying, "No data without stories and no stories without data." A story without something to stand behind it, when you're going to a physician audience for example, the story is meaningful but they want to see the data.

Kate: How is it that some teams and units are proud of their CAUTI/CLABSI rates? How do they get there?

Sam: First of all, I think teams get to that level of pride by first celebrating their success. We don't do that well in health care. We tend to just accept, "Oh, things went well." But if you think about the amount of effort it takes and the complexity of care that's being delivered to constantly have a good outcome, that is something to celebrate because you have incredibly sick patients who are

receiving very complex treatments, be it the medication, or be it procedures. And when you walk the process and you look at the elements that go into each one of those — I remember sitting with a team of pharmacists and nurses looking at medication administration. We spent eight hours in a room flow diagramming the medication administration process from order to when the patient receives the medication. One of the nurses stopped about halfway through the day and said, "I don't even know how we get a medication to a patient, let alone do it right," because the complexity of that process.

And so, not to say that when things just happen and they go right we should celebrate, but when we intervene and we change a process to make it better and we see that success, put it up on the huddle board. Make it visible for others to see. And you will create a sense of pride, a sense of ownership, which is really what becomes more important than the pride is that sense of ownership for what we've done. And what I've seen in certainly the ICUs that we've worked at as well as many other departments around the hospital, that creates a desire to do more because they can see they've made a difference, and the question is, "What's next?"

And to me when an organization that has ownership, has pride in what it does is not resting on its laurels, it's not using the hubris of success, but rather it's looking to raise to the next level.

Kate: I like that a lot. What incentives have you seen? So, you mentioned recognition and celebrating successes. I would imagine that incentives might play a part at some point in continuing to orient the team forward?

Sam: Incentives can take many different forms. It can be recognition, it can be publication on the intranet in the organization. You see 6 North had a success, they went 5 months without an infection, they went a year without an infection. I've seen hospitals that have certificates that they post on the wall outside of the cafeteria for everyone, the public included, to see, that says, "This team was successful in preventing infections for a year."

I remember in our work in Michigan with intensive care units around the state, we presented the certificate to every ICU that went at least 6 months without an infection. And we did it with a room full of 300 of their peers. It was a big deal. It was exciting. There was pomp to it. We've done that in other settings where we've recognized people with something that they can take back, put in the trophy case in the hospital or put on their wall.

Of late, and this is something that we began doing recently, about people who speak up to prevent harm, we will have a celebration at the organization where the individual who spoke up is recognized. And we have the CEO of the hospital there, we've had board members there, we will have the association CEO.

We will issue press releases, and so it gets published in their local paper, "Mary Smith spoke up and prevented harm for a patient." Those sorts of things have a way of increasing the desire for others to do the same thing because we all want recognition. And I think there also needs to be a balance. It shouldn't be like a youth soccer game where everyone gets a medal, but rather it should be recognizing when people do that extra to make a difference in care.

Kate: So, in thinking specifically about ICUs with extremely stubborn infection rates, if you had to boil this down, generating team buy-in and motivation, to just a handful or a few very practical how-to's, what would be your top three?

Sam: If a unit is experiencing an ongoing challenge with infections, I think the very first thing is to have an understanding and appreciation of the harm that's being caused. It goes back to engagement. I can give you all the data I want, but you're not going to get there. So if you see your rates posted and it's not there, let's make it personal. But once you've gotten people's attention, once they're at least understanding the why, because until you have the why it really doesn't matter. The next thing is that, "I'm not sure if we can really overcome this or not. We have a lot of trauma patients, and trauma patients, you're already at a higher risk for the infection." Identify the bright spots. Identify those cases that didn't go the way that you may expect. There's a lot to be said for understanding when things do work well, and let's walk that. Let's understand. We do root cause analysis when things go wrong. Why don't we do a root cause analysis on why it went right? Let's look at a positive outcome.

And then from that, can we learn then what the gaps are between our practice where things did go wrong and why is it this didn't? I look at event data when harm reaches the patient versus a near miss or a precursor event, and one of the things I find that's very common is precursor events, there was a point of communication along the way. In the harm event, communication was missing. And so, are we, as we think about the harm that we're causing, as we understand where our bright spots are, then how are we communicating with each other, and how do we bring knowledge forth so that all shifts are getting the same message around the interventions, that all are capturing the information they need to capture? And through daily goals or our huddles,

we're sharing our learnings and best practice that we're creating within our own team.

Kate: So, we've spoken a lot about the frontline staff and frontline providers. Talk about the clear line of sight that needs to exist between hospital leadership or senior executives in some of this work. How do we build buy-in and motivation at the multiple levels that it needs to be created?

Sam: I think it's easy sometimes when you're at the leadership level. Your focus is on the big picture and understanding what decisions are made at a senior level look like at the sharp end, at the point in which the patient is receiving care. I found that one of the most powerful tools is walk-arounds, or the senior leadership going out in a very purposeful way talking with people who are providing care, talking to the patients who are receiving care, but seeing what's actually happening. Ground truth. So that's, if you will, from the leadership to the bedside. Likewise, from the bedside to the leadership, often there is this lack of understanding of how do I communicate what we need in terms of resources to improve care to leadership? How do I make my case?

We had a CEO of a health care system come and talk to our ICU teams once a few years ago, and in typical CEO fashion it was a 15-minute talk. It was not a 45-minute with PowerPoint. And he related to them as a system CEO. He wanted to know very specifically what was the issue, what are the things that we need to do to address the issue, what will it mean in terms of resources, and that's people, dollars, whatever it may be, and how am I going to know you made a difference? We need our teams at the bedside to be able to take — and we can use SBAR, a TeamSTEPPS tool, to be able to frame those four things and bring it to leadership, bring it to your chief medical officer, your CEO, even your CFO.

I think this is the final thing. Things get put up the chain, if you will, and many times there's not a feedback loop. The people who are submitting the concerns or submitting the successes even never hear back. And that feedback loop is critical. So, we found in looking at culture data, looking at outcomes data, have found that where senior leaders get information and follow through, even if they can't make a change, even if it's something that is not within their realm to affect immediately, bringing that back to the staff to let them know, "You were heard. This is how we evaluated it, and this is what we're doing or we're not able to do, and why."

Kate: Just one more dimension that I would really love for you to speak to. Speaking to physicians specifically, tactics or coaching you might offer to them for building team buy in and continued motivation?

Sam: So, asking for physician buy in, first we know that physicians respond very well to data. Those who may respond well may also question the data, so it's vitally important that you're able to share data that has reliability and validity to it. The other thing is around evidence, and I've had experiences over the course of time where a physician will challenge the evidence. And the response that I've always had is, "I certainly understand your perspective, and I hear what you're saying. It would be really helpful if you could provide evidence to the contrary, because we need to learn. We need to understand if this is limited or there are other papers, other studies that provide greater understanding, please bring that forward because we all need to learn." So far, and touch wood, I have not had the experience where they come back with anything to refute, and typically they tend to then coalesce around the idea of this is the evidence and this is what we should be following.

The other thing that is a relatively routine reaction is when you put forward evidence and you say, "Here's the practice that we should be following," the reaction of, "are you telling me I'm doing it wrong?" And the fact of the matter is, no, it's either the evidence has evolved and practice needs to change to follow the evidence, or it may actually be a normalization of deviance. You've been lucky. You've practiced this way, and you may have not seen the outcomes be negative. The unhappy truth of that is the next one may be negative, and that may cost a life. And so, that's part of the uncomfortable conversation-having, and honestly that's best with physician to physician. And so, you identify a physician leader, and it doesn't have to be a formal leader, it doesn't have to be chief of staff or director of the unit, it can be the person that people trust and know. You get that individual on board and you arm them with what they need to move forward, and they begin to have those conversations either in medical staff meetings or individually, and coaching their colleagues.

Kate: I think that's really important to note, the peer-to-peer motivation, especially at the physician level. That's important clarity. I also recognize that when dealing with physicians, we need to overcome possibly some ego barriers in being corrected.

Sam: So, the power gradient is real, and it's something that is a critical point for leadership to be engaged in, because you have to have the knowledge that somebody has your back. The very first time that the nurse intercedes in a break

of practice, appropriately raises the concern, and the physician rebuts, that nurse has the backing of his or her manager. That carries a very loud and clear message. If that person is not supported, you just put a hole in the side of your boat and you're going to sink.

[*Closing music*]

Kate: Sam, thank you for your time today.

Sam: Thank you very much, Kate.

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 Sam Watson 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