

*ON THE CUSP:
STOP HA1*



Learning Objectives

- To understand the model for translating evidence into practice
- To explore how to implement evidence-based behaviors to prevent CLABSI
- To understand strategies to engage, educate, execute and evaluate





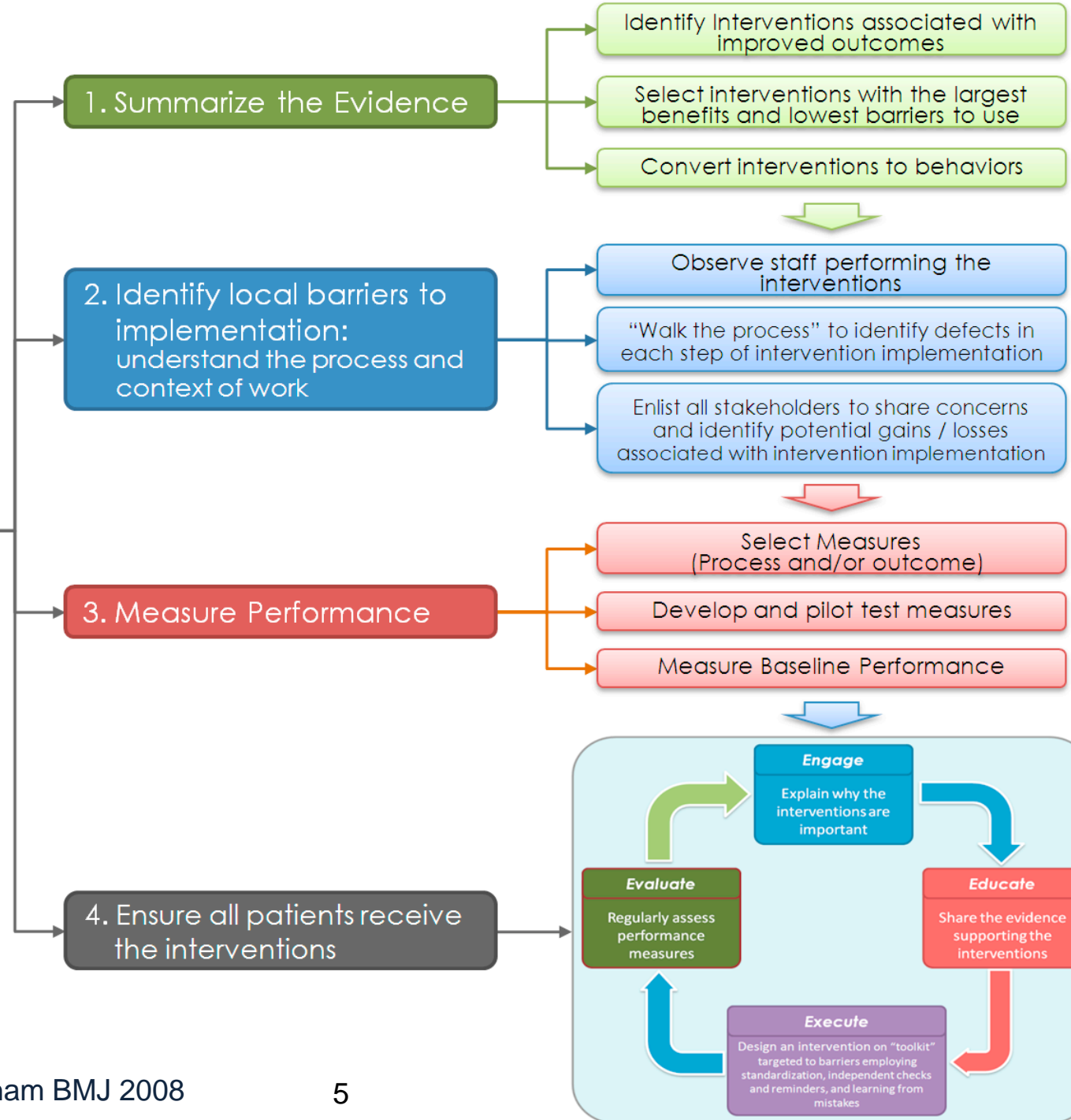
Goals

- Work to eliminate CLABSI
- Learn from two defects per quarter
 - One local, one central
- Improve culture by 50%



Translating Evidence into Practice

- Envision the problem within the larger health care system
- Engage Collaborative multi-disciplinary teams centrally (stages 1,2 & 3) and locally (stage 4)



Evidence-based Behaviors to Prevent CLABSI

- Remove Unnecessary Lines
- Wash Hands Prior to Procedure
- Use Maximal Barrier Precautions
- Clean Skin with Chlorhexidine
- Avoid Femoral Lines

MMWR. 2002; 51:RR-10



Identify Barriers

- Ask staff about knowledge
 - Use team check up tool
- Ask staff what is difficult about doing these behaviors
- Walk the process of staff placing a central line
- Observe staff placing central line

Ensure Patients Reliably Receive Evidence

	Senior leaders	Team leaders	Staff
Engage	<i>How does this make the world a better place?</i>		
Educate	<i>What do we need to do?</i>		
Execute	<i>What keeps me from doing it? How can we do it with my resources and culture?</i>		
Evaluate	<i>How do we know we improved safety?</i>		

Ideas for ensuring patients receive the interventions: the 4Es

- Engage: stories, show baseline data
- Educate staff on evidence
- Execute
 - Standardize: Create line cart
 - Create independent checks: Create BSI checklist
 - Empower nurses to stop takeoff
 - Learn from mistakes: review infections
- Evaluate
 - Feedback performance
 - View infections as defects



Partnership

- To help with 4Es, partner with
 - Infection control staff
 - Hospital quality and safety leaders
 - Nurse educators
 - Physician leaders

ICU staff must assume responsibility for reducing CLABSI



Engage

- Share about a patient who was infected
- Share stories about when nurses ensured patients received the evidence
- Post baseline rates of infections
- Estimate number of deaths and dollars from current infection rates (see opportunity calculator)
- Remind staff that most CLABSI are preventable.



Educate

- Conduct in-service regarding CLABSI prevention
- Create forum to jointly educate physicians and nurses
- Add CLABSI prevention to ICU orientation
- Give staff fact sheet, articles and slides of evidence



Execute

- Standardize: Create line cart
- Create independent checks: Create BSI checklist
- Empower nurses to ensure physicians comply with checklist
 - Nurses can stop takeoff
- Learn from mistakes: review every infection using learning from defect tool



Evaluate

- Monitor rates of infections using the Centers for Disease Control Definitions
- Post in the unit rates of infections per quarter (X axis is time)
- Post number of weeks or months without an infection

Action Plan

- Meet with unit team, infection control staff, quality and safety leaders, nurse educators and physician champions
- Understand barriers (walk the process)
- Use 4E grid to develop strategy to engage, educate, execute and evaluate
- Make weekly task list





References

- Pronovost PJ, Needham D, et al. An intervention to decrease catheter-related bloodstream infections in the ICU. *New Eng J Med* 2006 355(26):2725-32.
- Gawande A. The checklist. *The New Yorker* 2007 Dec. *Annals of Medicine* section.
- Pronovost PJ, Berenholtz SM, et al. Improving patient safety in intensive care units in Michigan. *J Crit Care* 2008 23(2):207-21.
- Pronovost PJ, Holzmueller CG, et al. A practical tool to learn from defects in patient care. *Jt Comm J Qual and Saf* 2006 32(2):102-8.
- Lubomski LH, Marsteller JA, Hsu Y, Boeschel CA, Holzmueller CG, Pronovost PJ. The team checkup tool: Evaluating QI team activities and giving feedback to senior leaders. *Jt Comm J Qual and Pat Saf* 2008 34(10):619-23.
- Goeschel CA, Pronovost PJ. Harnessing the potential of healthcare collaboratives: Lessons from the Keystone ICU project. *AHRQ Advances in Patient Safety: New Directions and Alternative Approaches*, in press.

