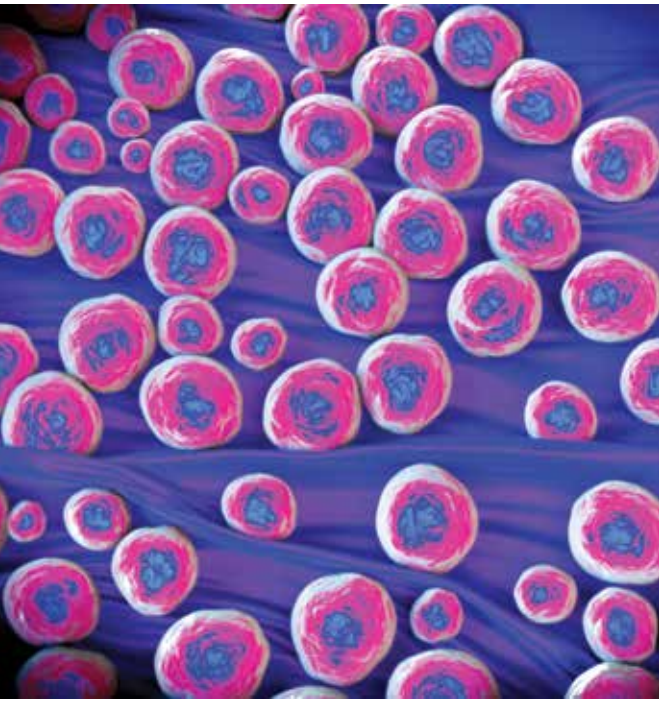
ROUNDTABLE

Healthcare-Acquired Infections: Culture Over Campaigns



Although healthcare-acquired infections have received widespread attention from hospitals, healthcare associations, and regulators, they remain a serious patient care issue and an avoidable high expense. The 2010 goal set by the Centers for Medicare & Medicaid Services to decrease HAIs by 40% by 2013—which would result in 1.8 million fewer injuries to patients—was not met. Starting October 1, 2014, hospitals with the highest rates of preventable HAIs will be penalized 1%, adding to existing federal penalties. Hospitals and health systems can invest in educating clinicians and cleaning staffs, enforcing proven measures such as hand washing, and installing systems to monitor rates following interventions. Yet HAI prevention and treatment depends less on procedures and more on culture, leadership, and organizational commitment, say five healthcare leaders who recently joined with HealthLeaders Media for an in-depth, three-hour conversation.

PANELIST PROFILES

MARILYN DUBREE, MSN, RN, NE-BC
Executive Chief Nursing Officer
Vanderbilt University Medical Center
Nashville

BILL GRANA
Senior Vice President and President, Workplace Health & Safety
UL Workplace Health & Safety
Franklin, Tenn.

GERALD HICKSON, MD
Senior Vice President for Quality, Patient Safety, & Risk Prevention
Vanderbilt University Medical Center
Nashville

WILLIAM MAPLES, MD
Senior Vice President & Chief Quality Officer
Mission Health
Asheville, N.C.

STEVE SEELEY, MSN, RN, CENP, CEN, CPHQ
Vice President, Chief Operating Officer & Chief Nursing Officer
Jupiter (Fla.) Medical Center

EDWARD PREWITT (MODERATOR)
Editorial Director
HealthLeaders Media
Danvers, Mass.

SPONSOR

Roundtable Highlights

HEALTHLEADERS MEDIA: *Let's say you get a text. It's an alert that there is a serious outbreak in your facility. What do you do?*

GERALD HICKSON, VANDERBILT UNIVERSITY MEDICAL CENTER: One critical element is what I refer to as the prework. Team members should be educated in advance that any kind of outbreak is possible, from MRSA in an ICU to flu throughout our hospitals. There is no time to deal with denial when your surveillance systems start suggesting a pattern that is more than random chance. Medical team members are reminded that infectious disease can walk in the door either via the patients we serve or by fellow team members. This is why constant attention to the details of prevention is so important, from using gowns and gloves to washing our hands at every opportunity. A second component of the prework is to establish a team of professionals who understand their duties and responsibilities in evaluating and managing a potential outbreak, including appropriate public messaging, culturing, testing, treatment, and prophylaxis.

WILLIAM MAPLES, MISSION HEALTH: You have to truly pause and do a thorough analysis of just what factors were contributing. That takes a multidisciplinary team to truly understand the magnitude and the significance of any outbreak. That allows ... the organization, as well as the public—if it does reach the public—to walk along with you and have an understanding of what needs to be done and what we're going to do to prevent this. That is because the biggest questions in everybody's mind are "Will this happen to me?" "Will this happen to my loved one?" and, "What are you doing as a health system to ensure the safety of each and every one of the patients who walk through the door?" Those are the critical questions that have to be answered at the end of the day.

STEVE SEELEY, JUPITER MEDICAL CENTER: It's important that you can respond rapidly and that your team is objective, so that they take the blinders off and can say, "Is this something that we have an issue or concern with?" I just went through a little test of that with *C. difficile*. We responded to two cases, so we didn't wait until it became a bigger problem. I think having a surveillance system in advance is critical so that you're monitoring real time. If there is an issue, hopefully you're finding it very early on before it becomes a bigger problem because this can really erode the confidence of your public.

With the different strains and the community-acquired bugs, it's becoming more challenging to identify "Is it us or not?" You can lose valuable time while you're trying to do the genetic testing to really understand that.

MARILYN DUBREE, VANDERBILT UNIVERSITY MEDICAL CENTER: Part of the prework is setting a culture that's transparent, one where there's surveillance rigor in place already so that the culture looks for answers. In our setting—and this is common in lots of other places—we're surrounded by people who are heroes in healthcare. They want to not have a problem, and they want to solve a problem if they see it. We're trying to make sure that no individual or no local team feels like "This is a problem we solve on our own." In fact we have a multidisciplinary team of experts who are epidemiologists, who are communication experts, who are culture and change managers.

HEALTHLEADERS MEDIA: *Marilyn and Jerry, how did the recent MRSA outbreak at your organization play out, from beginning to end response?*

DUBREE: As the data revealed themselves to us, there became an awareness that this was not an aberration. That this was not just one or two incidents, but we needed to look at this really differently. Then there was a stop and pause for that clinical team. This incident occurred in our neonatal intensive care unit. Then a very thorough campaign was mounted that was thoughtful and not rushed. ... But because we had deaths, it became very important to put a face on that. So that people could say, "This isn't just a set of lab results. There are infants who could be impacted by this."

Marilyn Dubree, MSN, RN, NE-BC
Executive Chief Nursing Officer
Vanderbilt University Medical Center

HICKSON: We have a great infection prevention team. The team has integrated themselves into operations and has worked with colleagues throughout the institution for years. They have earned the trust of others, and I can't tell you how important that is in a time of crisis. They're not going to jump up and down and create a crisis when a crisis doesn't exist. However, they can have the appropriate discussions you must have when trying to decide whether two or three cases constitute something more than random chance and there is reason for us to move beyond our routine practices.

DUBREE: With the right level of trust we were prepared to escalate our evaluations and interventions.

HICKSON: That's right. We reached a point when we needed to identify how many team members carried MRSA. To do that, we had to go into the unit and swab everyone's nose. As you can imagine, a subset of individuals, who are very good team members, looked up and said, "I'm not so sure about this." Such a response is reasonable, and with leadership commitment and trust, we were able to get the collaboration we needed.

BILL GRANA, UL WORKPLACE HEALTH & SAFETY: Risk management is extremely important—understanding what are your highest-probability events. Preparedness and practicing for these events is so critical; you don't want to be going through the mechanics of dealing with this for the first time if there truly is an event. The principles of emergency preparedness and the importance of practice are the same in an industrial environment as in a healthcare environment.

SEELEY: One of the things that strikes me is that element of trust. Really, does your organization have a culture of trust? ... People fear repercussions if maybe they're not following the proper procedure, whether it's a deliberate breach of practice or we have processes that are very broken. ... You really have to have an organization where people have the comfort level that they can come forward. In healthcare we don't like to make mistakes and we want to do the right things all the time.

Bill Grana
Senior Vice President and President
UL Workplace Health & Safety

GRANA: I think the reputational risk of undersharing or not sharing is far greater over the long term than erring on the side of oversharing. But it takes a lot of courage.

HEALTHLEADERS MEDIA: *You've all emphasized the importance of leadership. Talk about the different structures and approaches our readers can use.*

DUBREE: Our environment at Vanderbilt is that if one discipline decided to take ownership of a change—say the physicians decided to mount a campaign about X or nursing decided to mount a campaign about Y—then that doesn't work so well for us. We have seen the value of really explicitly saying, "This is a partnership; this is a collaboration."

When I talk to my colleagues across the country, I'll hear nurses say, "We really wanted to make a difference in hospital-acquired conditions," or, "We really wanted to make a difference in readmissions, but we just didn't have support from the physicians," or, "We didn't have support from finance," or whatever it might be. What are the decision rights around partnered relationships and paired leadership?

HICKSON: [Healthcare has] had a tradition at times of wanting to do things *for* the physician. You don't do things *for* the physician; you don't do things *to* the physician. You do things in partnership. Whenever I hear anybody talk about physician engagement, it means that, in that particular locale, they aren't engaged. Before a CEO runs out and hires some consultant, it's important to consider why. Some leaders really don't want [physicians] to share authority, but you can't get anything done that sticks without getting all of the parties in the room as decision-makers. Clinicians have insight essential to hardwire whatever it is that we want to collectively accomplish.

SEELEY: The CEO may help set the vision, but really it's the rest of the team that makes it happen. It's the organization's leadership, but you need your physician leadership as well. We have an independent medical staff, so we have to have good relationships so they understand the vision and our goals, so that they're participatory in it and hopefully engaged with that.

Gerald Hickson, MD
Senior Vice President
Vanderbilt University Medical Center

But it's hard. It's a lot harder than you think. I think everyone has to believe in that vision and goals. If we don't set that clear vision and really communicate that well, then all the efforts are going to be hit-and-miss. The sustainability just won't be there. You have to pound it home, pound it home, pound it home. Repeat and repeat and repeat so that people truly believe that this is what we want to do and we're committed to it. Your team will sense very quickly if you're wavering on that level.

MAPLES: I think it starts at the senior level of leadership, but where we have found our biggest challenge in effecting change is leadership at the manager and supervisor level. The middle management, if they are disconnected, no matter how hard you try, you're going to have an incredibly difficult time creating change. Things have to percolate throughout all of the leadership structures of the organization.

GRANA: Not to say that the C-suite is irrelevant, but on a day-to-day basis, the X factor is that middle management and supervisory level, who are the ones who really can make a difference for the positive, but also in the other direction as well.

HEALTHLEADERS MEDIA: *Does the board have a role with HAIs?*

SEELEY: Typically, boards have focused more on the fiduciary responsibilities than the rest of it. In our organization, our board is extremely committed to quality. We have a separate board quality committee, and they are a very engaged group because they want decisions to be made that are in the best interest of the patients even when we look at resources and things like that in regards to our outcomes. … The good part is there often is pushback and questions because they're not clinicians. They sometimes ask us very, very pointed questions—sort of like our patients would. Whereas we can always rationalize this and that and say why this data looks like this and this data point is here, [the board quality committee] does cause us to pause sometimes and say, "You know, that's a good point. Maybe we need to look at that with a little different eye."

If boards don't take [quality] seriously, then it's a big mistake. [Board support] is a commitment to your organization that it's taken that seriously and they're not just worrying about the finances. But those things really play hand in hand because if your quality is good, the dollars will follow.

DUBREE: We often regard our patient and family advisory councils to be our board, in addition to our Board of Trust and our hospital board. We have placed patients, like many facilities have, on quality committees.

MAPLES: It's critical to actually have the patients right there with the board as well as with all the other committees. To lead, [the board] first of all must understand what the landscape is and what the common vision is, and then it's most important that they support and take action because that gives a message to the entire health system. Do they really financially support the initiatives that are necessary to drive safety?

HEALTHLEADERS MEDIA: *What are barriers to a hospital culture of prevention and safety?*

HICKSON: First, we must recognize that our clinical partners are not adversaries. The vast majority embraces safe practices and early reporting and addressing of what I refer to as "disturbances in the force." Unfortunately, just a few are not going to comply with evidence-based best practices—for example, an individual refusing to fully gown while inserting a central line. So, when an individual says "Heck no," other professionals have to look each other in the eye and ask, "Are we really committed to mutually supporting right practice?" I'm on a soapbox, but many medical leaders have at times the inclination to look the other way. As leaders, our nature to be conflict-avoidant is a major stumbling block to a culture of safety.

GRANA: Other barriers are productivity demands. You have tension between the operational folks and the demands that are put on you in a healthcare setting by the volume of patients. That causes clinical staff, who know better, to take shortcuts. The easy thing is to point the finger at those people, but that really isn't the root of the problem. It's the environment that is creating the pressures to cause people to take those shortcuts. If your boss is telling you you need to move faster, which may be in conflict with quality and safety issues, it's hard for many individuals to balance those competing interests.

HEALTHLEADERS MEDIA: *How do you set up surveillance systems and make sure that you're finding out what you need to know—even while knowing that the data is going to be imperfect?*

William Maples, MD
Senior Vice President
& Chief Quality Officer
Mission Health

SEELEY: We've tried to capitalize on the electronic record to pull out the data points and things that we want to look at. So we have real-time lists of Foley catheters and central lines and ventilators. We're also looking at the culture report. It's much more of a push mentality as opposed to having to go in and pull the data, because then we won't look at it as frequently. … I don't know that people always optimize our EMRs the way we should for some of these things. Having that data in hand real time is much more effective because you can act on it much more timely.

HICKSON: I want to be sure that people have access to a quality and safety dashboard. There must be a clear understanding of the process by which we expect data to be reviewed and an escalation process if needed performance improvements are not seen. Responsible medical, nursing, and administrative leaders need to know that on a predictable basis, we are going to be back knocking at their door.

HEALTHLEADERS MEDIA: *So the surveillance system is really the data plus the people.*

HICKSON: A surveillance system is not just a tool. It must be associated with defined processes and responsible people. Otherwise [the data] just sits there. It's the process that makes the data actionable.

MAPLES: Our latest two outbreaks actually were not detected by the electronic surveillance. In addition to electronic surveillance, there are several other inputs that signal what is daily occurring in the health system. These [detections] were by people being willing to ask questions when a pattern is occurring in the unit to say something is not right. In the first outbreak, we had three patients come back to back on one day from surgery, all to one unit, and they were all covered with blisters. So the question was, what in the world is happening here? Do we have an infectious problem going on? It was our clinical staff that was astute to say, "Something needs to be looked at," so we immediately mobilized our multidisciplinary team to begin the evaluation that evening. ... In the second outbreak there was an infection, but it wasn't an infection that was monitored in the electronic surveillance system at that time. Part of the surveillance system is your people on the ground looking at your patients every day.

SEELEY: When you talk about your frontline staff, don't underestimate the nonclinicians: environmental services folks and people like that. They can be great eyes and ears and observers, and they often pick up on trends and noncompliance ... that maybe the clinicians aren't in tune to.

GRANA: One of the things that we see on a regular basis in hospital environments is that worker health and safety very often is separate from quality and patient safety. I think that's an issue that many institutions really need to address. Typically within a hospital environment, patient health is led by a different person than employee safety, which often is managed as part of security ... Yet worker safety plays a critical role in patient safety. If you can't get the worker safety component right, you have no chance on patient safety.

HEALTHLEADERS MEDIA: *If hand washing were 100%, would that take care of HAIs?*

HICKSON: It would help. If I consistently practice hand hygiene, it creates a kind of discipline. For central line placement, if we look at insertion bundles, the first element is to wash your hands. If we're going to deal appropriately with prevention of CAUTIs, we need to wash our hands. If we're concerned about ventilator-associated pneumonia, we need to wash our hands. It is the age-old issue of attention to detail. If you really think about one of the greatest threats to the infectious disease challenges we measure, it's a lack of attention to detail. That is why a focus on hand hygiene is so important. It's not just washing your hands; it symbolizes to an organization that it is really committed to a culture of safety.

HEALTHLEADERS MEDIA: *How much do you depend on federal, regional, and state groups for HAI prevention?*

DUBREE: Regulatory agencies and professional organizations like the American Hospital Association, by the time they're giving you info on what to do, they often have responded or reacted to things that have happened in the past. Other groups like collaboratives ... do create a lot of partnership and learning. They create resources that help you learn from others' successes and perhaps where they stubbed their toe and made a mistake. That's been really powerful for us. We use those regularly because we think we have often something to offer, but more often than not we have something to learn.

MAPLES: If you look at Premier and their learning collaboratives, like their Quest project, it's undeniable that they have, through collaborative efforts, driven phenomenal improvements in quality in terms of infections.

I think the next place to look is the federal Hospital Engagement Networks. Recently their network submitted for another year of funding based on their successes. The North Carolina-Virginia Hospital Engagement Network has had incredibly positive results from the initiatives that they focused on, in particular CLABSIs. The results for CAUTIs were not so good—they were actually flat. Many of the other efforts on healthcare-acquired conditions were successful.

Steve Seeley, MSN, RN, CENP, CEN, CPHQ
Vice President, Chief Operating Officer
& Chief Nursing Officer
Jupiter Medical Center

HEALTHLEADERS MEDIA: *Half a dozen HAIs have been focused on in recent years. Are they the right ones? Are there other emergent or big-picture things that should be focused on?*

MAPLES: There are tremendous opportunities for healthcare-acquired infections that are knocking on the doorstep. Where I would put my next focus is antibiotic stewardship, which is incredibly important in decreasing healthcare-associated infections. In the long run, that is going to be a key to keeping our patients safe.

SEELEY: One thing that popped up recently was peripheral line infections. We have focused on central line infections, but peripheral line infections are becoming a little more problematic. Everybody has an IV, so we are putting a new focus on that now.

GRANA: I am not entirely confident that we are doing the best job that we can be or should be in our sterile processing. There are many new companies introducing software and other technology-enabled solutions in this arena. There is a large bucket of work there that will likely have a profound impact on patient safety as well as their infections.

Reprint HLR0514-6

IMPROVE WORKFORCE HEALTH AND REDUCE HAIs

Healthcare workers carrying communicable diseases can infect patients. How does your organization promote worker health?

With OHM, UL's EMR for employee health, help ensure worker health and reduce the spread of HAIs.

Learn more at ulworkplace.com/ohm.