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

Transcript

How To Empower Staff To Speak Up To Stop a Central Line Insertion if They See a Breach in Aseptic Technique, Including How To Obtain Buy-In From Physicians

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

Today, we're discussing how to empower staff to speak up to stop a central line insertion if they see a breach in aseptic technique, including how to obtain buy-in from physicians. Anne, welcome.

Anne Donovan: Thank you. It's a pleasure being here with you today.

Kate: So, let's start with, why might staff be hesitant to speak up? What are they afraid of?

Anne: I think the biggest thing to address here is the culture of a hierarchy in medicine. I think this is a more traditional concept that is going away over time in favor of establishing a more sort of collaborative interprofessional care team in the ICU, but it still does exist. So, for example, a nurse maybe who is new might be afraid

to tell a doctor that he or she has had a breach in aseptic technique for a number of reasons. They may just feel like it's not their place. They may feel like they're going to be told that they're wrong. They may feel that their concerns are going to be brushed off.

A junior physician also might not feel like they can sort of stand up to their attending or to somebody who's more senior than themselves. So, trying to find a way to break down that hierarchy that still exists in medicine, I think is an important first step.

Kate: What practical steps do you think a team can take to respectfully break down hierarchy, which might hinder infection prevention improvements?

Anne: Encouraging a collaborative interprofessional environment throughout the entire ICU, not just with respect to infection prevention but sort of in all of the day-to-day work that happens in the ICU is really important. Things that can be helpful include interprofessional rounds where nurses, physical therapists, pharmacists, respiratory therapists, and other people who are stakeholders in patient care in the ICU discuss their concerns and questions they have about patient care for the day, in addition to the physicians reviewing patient data and talking about the plan for the day. Integrating patients and families into rounds is also another thing that you can do to sort of bring patients and families into the center of this conversation as well.

And beyond that, thinking about the way that we communicate in the ICU is really important. A lot of this responsibility lies sort of with the physician as the traditional top of the hierarchy or the head of the team to listen actively, invite questions and concerns, and to make people feel like they're empowered and encouraged to speak up when they see something that isn't right. We should all keep in mind that we're all trying to do the best thing for the patient, and the patient should always be at the center of everything that we're doing in the ICU.

Kate: So, if I'm a physician, why do I want the hierarchy to change? Why is it important that it's broken down?

Anne: As a physician, you see a lot of what happens in the ICU, but you're not the person who's actually in the room with the patient for most of the day. Other frontline providers, like nurses and respiratory therapists and physical therapists, have a really important perspective that comes with actually being really hands-on with the patient and their day-to-day care activities, and I think can bring up a lot of really, really important perspectives and concerns that you

may not have even thought about as the physician who's writing orders and seeing the patient maybe a couple of times a day and doing a lot of documentation.

So, I think it's important to change that attitude in favor of one where everybody in the ICU has an important perspective, and we all have different training backgrounds and different lenses of looking at what's going on with the patient that can all really contribute to improving the care of the patient.

A really simple thing that people can do to start the process of breaking down hierarchy in the unit culture is to learn and use each other's names. It may sound really simple, but it's an easy step that can be taken. Teamwork data actually supports that when people have met each other and are familiar with each other and each other's roles, communication is better in crisis situations.

Kate: Are there any practices that you know of that would make it easier in that moment of high stakes for the nurse to speak up?

Anne: Some ICUs have implemented a timeout protocol so that before every procedure or central line insertion, the nurse and whoever is placing the central line pause, identify the patient, identify the procedure, and go through some important safety steps. I think even just establishing that level of conversation makes the team involved in the procedure more familiar with each other, and would make it easier for someone to step up and bring up a concern in the moment if it were to occur.

Kate: So, imagine that you're coaching one on one with a timid nurse, and they happen to be working with a very notoriously stubborn physician, let's say. How would you coach the nurse to speak in the moment? We can talk about anything from content to tone to timing. What comes to mind?

Anne: I would always encourage them to remember that they're the patient's advocate in the moment. Sometimes people use kind of the, quote-unquote, “mom test.” So if this patient was your mom or was a loved one of yours, what would you want the nurse or the physician to do? So, if an individual is having trouble sort of getting the courage to speak up, just kind of remember that you're trying to advocate for what you think is best practice, not only for your patient but what you would also want for yourself or a family member if they were in your position. I would also coach the nurse to be confident and try to not be timid.

You're really just making an observation, and it's up to the person who is on the other side of that conversation to respond appropriately.

Kate: Well, that's a great point. How would you coach the doctor in that moment? Where they might feel disrespected if it's not conveyed perfectly, or if I'm especially stubborn, maybe I just don't want to hear it, especially in front of a patient. There might be some concerns there. How would you coach the doctor to listen?

Anne: I would coach the doctor to be receptive to the nurse's input. Again, they're trying to bring up something that really is standard of care. And, you know, we all make mistakes, we all sort of breach our sterile barrier from time to time. And if you don't notice it, you should actually thank somebody else for bringing that concern up to you. So, I would thank them for bringing up their concern, and I would — again, the way, the tone in which you respond and the way that you communicate with that nurse is going to affect the way he or she will feel about bringing up concerns in the future.

So, if you're a nurse or other provider who's bringing up a concern like a breach in a sterile technique, do so in a way that's observational and not accusatory. That is really going to affect the way that the person that you're talking to receives your feedback. So, if they feel like they're being attacked or accused, they might not receive it quite as positively as if you say something like, “I just observed that your hand brushed against something unsterile.”

So, if you see that a proceduralist’s glove got contaminated during the procedure, offer to bring them a new set of gloves. Don't just say, “Sorry, your glove is dirty.” And then walk out of the room. It's obviously not helpful. Somebody has scrubbed into a procedure. They would have to completely unscrub, resterilize. So, be helpful. Say something like, “I noticed that your glove got contaminated. Can I grab you a new pair?”

During central line insertion, nurses can really embrace the role of being a second set of eyes for the physician or the person who is placing the central line.

And they might be the person who notices a breach in aseptic technique, even when no one else does. So even during the central line procedure, the nurse can continue their role as patient advocate. And so, again, bringing the patient back into the center of the central line sterility might be able to help be a motivator to somebody who feels too timid to speak up.

So, internally, if I'm afraid to speak up, I might be thinking to myself, “Well, this is important for the patient. I am the patient's advocate for right now, so I'm going to say something.”

Now, if the physician is not receptive to what you say, then you can bring the patient back into the center of it and say that sterile technique is really important for preventing central line infections, and so you think it's really important to pause the procedure and resterilize.

Kate: How would you coach the doctor to listen to that input?

Anne: We all are aware of how important aseptic technique and sterile fields are when placing central lines. And so, as a rule, you should be open to having someone tell you that there was a breach in the sterile field.

When a provider brings up a question or concern, it's OK to disagree with what they're saying, but it's really important not to be dismissive and to help them understand why you disagree. It may end up being a teaching moment both for that provider and/or for you.

In many situations, time is of the essence, but safety should always come first. It may be necessary to reprioritize and to relearn some of the habits that we've all been doing for, in some cases, a long time, but this culture of safety really should be coming sort of to the forefront of all of our efforts.

It's also really important to preserve that feeling of team collaboration and respect for everybody's role and perspective and background throughout this whole process. Speaking up in advocacy for the patient is part of every health care provider’s role. It's not a choice, it's an expectation and a requirement. And so, we all should be reorienting the way we think about either speaking up or receiving feedback from somebody else who has decided to speak up so that we encourage that behavior to happen on an ongoing basis.

[*Closing music*]

Kate: Anne, thanks so much for taking the time to speak with us today.

Anne: Thank you, 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 Anne Donovan for joining us today.

To learn more about safety issues in ICUs and CUSP in general, visit ahrq.gov/hai.

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