**On the CUSP: Stop CAUTI in the ED**

**ED Mini-Presentation to Accompany April 7, 2015 ED Coaching Call**

Sarah: Hello, everyone, and thank you for listening today. My name is Sarah Dalton and I am a research specialist with the Health Research and Educational Trust.

 Welcome to the second mini-presentation in the CAUTI ED Cohort 9 educational webinar series. Today's topic is Integrating Teamwork Tools into CUSP Efforts. We encourage you to watch the short presentation with your team. At the end of the presentation there are a few discussion questions to talk about as a group, before joining the April 7th ED coaching call hosted by the New Jersey Hospital Association.

 Today's presenter is Shannon Davila. With a clinical background in adult critical care, Shannon specialized in infection prevention and quality improvement while in the acute care setting. In 2012, she began her career at the New Jersey Hospital Association's Institute for Quality and Patient Safety. As a clinical quality improvement manager, Shannon provides support to hospitals through quality improvement initiatives, such as On the CUSP and TeamSTEPPS. Shannon is the New Jersey State Lead for several CUSP projects including Stop CAUTI, BSI, CUSP for MVP, and SUSP. Shannon is certified in infection control, health care quality and is a TeamSTEPPS Master Trainer. She received her BSN from the University of Southern Maine and her MSN from Walden University. Now I'll turn it over to Shannon.

Shannon: Thank you Sarah. Welcome everybody to our mini-presentation for the ED CAUTI Project. Today we are going to be really briefly going over some of the critical [TeamSTEPPS 00:01:36] tools and how those tools can be associated and enhance our CAUTI efforts. To begin, we really need to understand where teamwork fits into our CAUTI reduction in the emergency department. Let's just quickly review the Emergency Department CAUTI Project goals. Now of course we have the technical change which is where we look at catheter appropriateness. This is where we focus a lot of our efforts in educating our staff, our clinicians over the reasons why patients should have a catheter placed or should not have a catheter placed. Another area where we focus a lot of our attention is on promoting proper insertion techniques, primarily, sterile or aseptic insertion techniques and ensuring competency of our staff. There are other important elements of this project, particularly around culture change that have to be in place in order for this to be a successful initiative.

 The items highlighted here in red are really critical to our success. Teamwork and communication among our frontline staff. Having leadership support our project in the form of nurse and physician champions really helps to gain buy-in and be successful. Then, of course, collaboration with inpatient units. These are more challenging and without a culture and an environment that really promotes teamwork and collaboration, we can find it difficult to improve quality.

 In a perfect world these goals would be really easy to achieve, but in reality there are barriers that exist to our team performance. When we look at some of the different barriers that teams may run into, we can look at inconsistency in team membership. Sometimes team members may not have the time to participate or you have turnover.

 Lack of time, of course, everyone's really busy, we're caring for our patients and sometimes people aren't able to prioritize their role or their time dedicated to this quality-improvement initiative. Lack of information sharing. If you're not receiving updates on what your data looks like or any new processes put into place, you can have some communication errors that occur from that.

 There is hierarchy and defensiveness among staff. Conventional thinking, we've always done it that way. People not being able to consider change because historically they didn't do it that way. Varying communication styles, which can sometimes lead to conflict among team members. Lack of coordination and follow-up on different events and changes that are going on, distractions in the workplace, maybe personal distractions. Fatigue and work overload. We're all busy. Many of our clinicians work 12-hour shifts and take care of many different patients and deal with crisis throughout the day. That can be really exhausting. Lack of role clarity is another one as well. Folks may not understand what their role is on the team, so they're not able to function as best as they could if they had a better direction of where they fit in and what goals they were trying to achieve. These barriers can lead to issues with communications and care planning for our patients. Also, potential patient safety issues which, as we know, can lead to harm and adverse outcomes.

 When we look at TeamSTEPPS and CUSP, these are two models, which of course, we're all familiar with the CUSP model, engaging the frontline staff, but when you add a model like TeamSTEPPS, it can really enhance the performance of the quality-improvement initiative. There you see the link that will bring your staff directly to the TeamSTEPPS website for more information about some of these tools that we're going to talk about in just a moment.

 Let's just talk real briefly about what is TeamSTEPPS. It's a way to address barriers to team performance. Really the principles of TeamSTEPPS focus on improving leadership, improving communication amongst team members, situation monitoring, knowing what's going on around you within your team, and mutual support of your team members. TeamSTEPPS is an evidence-based program based on more than 30 years of research and evidence. It really started with looking at the aviation field and how the communication and teamwork that went on between copilots and [inaudible 00:06:06] the pilot. When they saw advances in safety in that field, the medical field adopted this. It actually began with the Department of Defense and emergency departments is where it originally came to health care. It provides a roadmap to creating high-performing, multidisciplinary teams in any setting and even though we're talking about emergency departments today and TeamSTEPPS began in the emergency department, many hospitals and health care settings have adopted it across the continuum of care. We've seen it now used in ICUs, and perinatal, the operative setting, long-term care, anywhere you have folks that are working together to accomplish goals for patients, you can implement TeamSTEPPS.

 Here this diagram shows the principles that I mentioned before of leadership, communications, situation and monitoring, and mutual support, but to implement these skills, what we're hoping to do is improve on our performance of our teams. We're hoping to change and improve attitudes of those that are involved in the team and to increase knowledge of these skills and how we can improve patient safety.

 Let's talk about some of the actual tools that are part of TeamSTEPPS. The first set of tools are around leadership. Three key items here which many people are familiar with, would be briefs, huddles and debriefs.

 Briefs are about planning and it's really just to have a quick session to bring people together before something [inaudible 00:07:42] an event or the day or the shift. It's really to assign roles, establish expectations, and then allows folks to anticipate what outcomes and goals they should expect by the end of the shift.

 Huddles are more about problem-solving, pulling the team together really quick if there's an event that changes, or something unexpected happens, just to get everybody back on the same page and to discuss any new plans or course of action.

 Debriefs are about quality improvement. This typically occurs after an event or the end of the shift or an OR case or something. This is really where team members are able to exchange information about what occurred, positive and negative.

 Some of the communication tools that TeamSTEPPS highlights would be the SBAR, which many of the hospitals are familiar with this: situation, background, assessment, and recommendation. This was the tool that originally was adopted by teams as a way to communicate critical patient safety information and maybe at urgent times, but now we've really seen it adopted as a standardized communication tool. We've seen it used for handoffs, shift-to-shift handoff, for handoff between emergency departments and inpatient units. It's just a really nice organized way for clinicians to present the key information that they need especially during transitions of cares or whenever patients are moving from one area to another.

 The call-out is a way for people to vocalize information so that everyone on the team can hear what's going on. It is really about putting it out there. Everyone acknowledges the key information.

 Check-back is the form of closed-loop communication, in which you're validating that the message you're putting out there has been received by the people that you really need to hear it.

 Handoffs as we just mentioned. [There's 00:09:36] many different forms of handoffs, but it should be an organized approach, especially during times of transitions of care, when information can be exchanged in a timely and effective way. It also allows the opportunity to question if people have any issues or things seem unclear.

 Situation monitoring tools. This is about really understanding what's going in your environment, not just with your patients, but what's going on with your co-workers. It helps to anticipate what may come, helps you be prepared if the unexpected were to happen.

 Cross monitoring is a tool. This is about watching each other’s backs, ensuring mistakes and oversights are caught. This isn't about tattling on someone or being nosy. It's really about paying attention to what your co-workers are doing, they are paying attention to what you're doing and if either of you seem like you are in a situation where need a little, you might need some backup, that's what it's about.

 The STEP checklist is an organized way to be able to assess what the situation is on the unit, how your team members are functioning, what the environment looks like, and if you're moving towards your goal.

 The I'm SAFE checklist is really just about the health and well-being of your co-workers. It's about assessing for illness, stress, and fatigue, of course, we all experience these things, but to have a really strong culture of safety in your unit where the team is functioning properly, folks need to be feeling their best and supported in doing so.

 Mutual support tools. We have task assistance and this is protecting each other from work overload, being there for one another. If you have a moment where you're caught up, but you see your co-workers struggling with something, just offering your help. Some folks are afraid to ask for help or to offer help, but mostly people may feel that if they ask for help it shows a sign of weakness. If you have a culture where this is encouraged, hopefully that won't happen. Feedback is really important, as well. Being able to provide positive and negative feedback and not just to provide but to receive feedback.

 Advocacy and assertion. Being able to stand up and speak up when you see something that you think needs extra attention. Being strong, but being respectful in the way that you do that. The two-challenge rule is a tool that is really about advocacy and assertion. If you have a clinician and they're seeing something that perhaps they think is a potential safety issue and they speak up and they say, "Hey, I'm kind of concerned about this. Maybe we should try a different approach." If your first time asserting your concerned is ignored or if the other person isn't going to pay attention or follow your recommendation, it's about stepping up that second time and saying "Hey, I think you should really listen to what I'm saying here. I'm really concerned about this patient and I think we maybe [inaudible 00:12:45] try a different course of action." It's a two-challenge rule. It's not giving up on that first try, but it's going back for the second and really making your concerns known, and again, this is because you're concerned about the safety of the patient.

 CUS, C-U-S, is a nice tool. I've found that especially with nursing students, this is a way to really help them find their voice, particularly when they're not used to speaking up or they're afraid to speak up to physicians or to more senior nurses. This is just a way to say, "I'm concerned, I'm uncomfortable, and this is a safety issue." It provides them with a framework to speak up and advocate for their patients, again always in the name of safety.

 The DESC script is a conflict management tool that can be used by team members, nursing managers, folks that are trying to handle conflict between co-workers, and, of course, collaboration is key to teamwork, particularly when you're talking interdepartmental or within different departments as well.

 Those were the tools really quick in a nutshell. Now, we're going to look at how we can apply some of the tools to our CUSP CAUTI efforts. When we look at, for example, one of the goals of the inpatient units was to reduce CAUTI rates by 25%. How are we going to achieve that through CUSP? We work on safety culture and part of that is improving teamwork and communication, and when we bring in the TeamSTEPPS tools, for example, the briefs, huddles, and the two-challenge rule, we can actually give those team members some hands-on tools that they can use to really enhance their efforts.

 Here's some examples of how we can use some of the tools and some of the teamwork challenges that you can use the tools for. Avoiding unnecessary catheter utilization in the ED. This is something that we're all working on in our departments. Failing to discuss or have plans for catheter removal or assessment of appropriateness. Concerns about being able to toilet patients due to high workload. I'm sure many people have run into this with short staffing and lots of patients, it can be difficult to get patients up and to toilet them. Failure to clarify who owns responsibility for continuing to leave catheters in patients. Who do we go to when we're asking those tough questions about who was responsible for this? Then the perception that CAUTIs are not important since infections are easily treated.

 When you look at some of the [TeamSTEPPS 00:15:22] tools, of course, task assistance is a big one. Everyone pitching in, organizing to get the folks at the bedsides that can help get that patient up to the toilet or to put them on a bedpan. Briefs are a nice tool to use when you're talking about the plan of care or maybe to get the catheter out of a patient that doesn't need it anymore. Maybe it's your heart-failure patient who’s been diuresed and now they no longer are having difficulty breathing and they don't need the catheter. Then, of course, the CUS and the two-challenge rules which help you advocate for your patients. Express concerns about unneeded catheter insertion or retention.

 Now that we've talked about the tools, we're going to look one scenario here and see where can we apply these tools. I think many of you will be able to relate to some of these issues that happen here in this scenario.

 An ED nurse is assigned to an 87-year-old female patient being seen for possible wrist fracture after a fall. The ED physician is a family friend of the patient's daughter and orders a urinary catheter after the family's request for one, due to their concerns the patient is unsteady and not safe to ambulate to the bathroom. The nurse knows that the patient does not need a catheter and there are alternatives that would be more appropriate and safe. Despite her concerns, the nurse places the catheter because the physician made it clear that the family wants it and he does not think it's a big deal since, in his words, "The patient won't be here that long and it will allow her to rest."

 X-rays show that the patient does not have a fractured wrist but does have some nodules on the chest X-ray that look suspicious. Orders are written to admit the patient. Due to high census the patient is held in the ED and over the next 24 hours, the patient repeatedly pulls at the catheter attempting to remove it. Additionally, the patient makes several attempts to climb out of bed and is found on the floor at one point in the night. To rule out any injuries, the patient is seen for a head CT along with a chest CT for the nodules, but during the transport and tests, the care technician places the urinary catheter collection bag on top of the patient while the patient is on the stretcher. The nurse notices this does but does not move the bag. The patient is later admitted and two days later a urine specimen's collected and a culture shows that the patient has an *E. coli* urinary tract infection. The patient is started on IV antibiotics that end up extending her admission at least three more days.

 What are some opportunities that we saw in that scenario that we could use the TeamSTEPPS tools for? Well, definitely a huddle. The ED team could have pulled together to make a plan on how could they best care for this patient, who was going to toilet her, could they have used a bedpan or any alternatives. Task assistance, the ED could definitely worked together to make a plan of who was going to toilet this patient. The CUS or two-challenge rule, there was a definite opportunity there for the nurse when she knew in her gut that that was not the right reason to put that catheter in. She should have questioned the need for that catheter and she could have used the CUS or the two-challenge rule as a respectful approach for discussing that with the physician. Finally, cross monitoring, of course, that RN did see the CT tech put that collection bag on top of the patient, knowing that's not the right place for it to be, causing urine reflux. They could have taken that opportunity, in a respectful way, to educate the CT tech on why it's important that that collection bag was hung below the level of the bladder.

 I want you all as an ED team to really think about these discussion questions going forward. How have your team members experienced situations in which any of these tools would have been beneficial in your department in a scenario similar to this or something even different? What is the biggest area of need for your team? Are you lacking in leadership? Is there opportunities for better communication, situation monitoring, or mutual support? Within those principles, what tools could you use to improve in those areas? Does your emergency department have formal teamwork training program in place, and if so, how can CAUTI prevention be integrated into that program? I would encourage you to get with your ED educators. There's probably a chance that you've had some teamwork training in the past and maybe it's time for a refresher. If they do that, I would encourage your educators to integrate some of these CAUTI principles that we've talked about with the [TeamSTEPPS 00:19:51] tools and apply them in a practical way that the staff can use them in their everyday practice.

 With that, I will leave you with these discussion questions. Thank you for listening to my mini-presentation today. I'm going to turn it back over to Sarah.

Sarah: Thank you so much Shannon. Please remember to fill out an evaluation of this mini-presentation at the link on this slide. We hope you will join us for the upcoming April 7th ED coaching call at 2pm eastern where Shannon will be available to answer any of your questions that you might have regarding these teamwork tools. Thank you again for joining us.