Making It Work Tip Sheet

Celebrating Success and Spreading CLABSI and CAUTI Prevention Beyond the Unit

This "Making It Work" tip sheet provides additional information to help intensive care unit (ICU) team leaders implement effective strategies and achieve goals to reduce central line-associated bloodstream infections (CLABSI) and catheter-associated urinary tract infections (CAUTI) and improve safety culture at the unit level.

Issue

Recognizing success, large and small, both early on and long-term is important to sustainability. Communicating success can help frontline staff gain the courage to speak up more frequently because it reinforces that their actions and voices are valued and make an impact on patient safety. In complex and fast-paced healthcare environments with multiple competing priorities and initiatives, recognizing and celebrating success is often forgotten. Celebrating success need not be elaborate, and small gestures can go a long way to motivate staff and providers. Effective leaders and managers should always acknowledge unit teams that achieve safety goals or make significant progress toward them. Recognition of individual team members at hospitalwide meetings and in newsletters motivates staff to sustain patient safety work.

In order to continue successes and work toward sustainable changes, spreading to other areas outside of the ICU is key because CLABSI and CAUTI prevention goes beyond the ICU. ICU teams have a unique opportunity to work with other like units and departments (i.e., other ICUs, emergency department) as well as the transport teams to spread best practices. Once key interventions have been successfully piloted in an ICU with positive results, consider rapidly sharing the changes with other units. Challenges exist when the organization may not have the capacity for a systemwide implementation process, or the practice areas are not allowed to adapt the new process to different unit cultures and patient populations. Spread of knowledge and practices is facilitated when other units become inspired to adopt these safety practices that are recognized and rewarded elsewhere in the organization.

Suggested Strategies

Celebrating Successes

- Ensure success is communicated regularly and rewarded often. Consider collaborating with your facility's communications department to identify opportunities to promote successes internally.

- Create a visual display of the team success on the unit to be shared via a performance management board or a bulletin board in the break room. Consider including baseline data, key interventions, and the outcome(s) achieved.
- Define milestones of celebration at initiation of the project, such as "100 days without an infection," and how you will celebrate the success. Some examples include cake, a pizza party, a certificate of recognition signed by an executive leader, or a write-up in the hospital newsletter.

Spreading CLABSI and CAUTI Prevention

- Through examination of data, identify areas in the hospital that may have the most opportunities for improvement and can adopt new practices easily.
- Share your team's story success with other identified units, senior leaders, quality committees, surveyors, boards of directors, and patients and families.
- Consider asking senior leaders to share successes broadly within hospital and on various social media platforms.
- Obtain local leadership's commitment to adopting the new practice.
- Overview the new practice/process with the other units/areas clinical team. Discuss the whys through data and storytelling. Explain the nuts and bolts of what you did using the Plan, Do, Study, Act (PDSA) cycle.
- Test it at a small scale before full adoption.
- Discuss barriers and how you overcame them, which may include financial analysis.
- Interventions may need to be adapted to accommodate special situations in other ICUs or areas depending on the types of patients. For example:
    - A burn ICU may need to have different dressing change processes related to securing the dressing on a central line; and
    - General care areas might need a central line bag insertion kit instead of an insertion cart

Conversation Starters – Spreading the Gains

To assist in spreading the innovation to other areas (like ICUs or other departments) to reduce overall hospital CLABSI and CAUTI rates through technical and adaptive interventions, consider using the SBAR (Situation-Background-Assessment-Recommendation or Request) technique to prepare for a conversation with the manager or clinical nurse specialist of another unit. Below is a sample script of Laura (surgical ICU (SICU) manager), whose units successfully reduced CAUTI, speaking to Jack (medical ICU (MICU) manager):

Situation: "Jack, what did you think about the presentation that my unit, the SICU, did at the leadership meeting on reducing CAUTI? When I (Laura) look at the hospital data, it shows that the MICU's utilization is higher than expected benchmarks."

Background: "The SICU was experiencing the same challenge 6 months ago before we started our improvement project. We formed a multidisciplinary team that reviewed best practices and identified gaps."

Assessment: "I see that the MICU does not yet have an organized multidisciplinary team focused on CAUTI reduction within your unit."

Recommendation/Request: "I would be happy to sit down with you, Jack, and walk you through the process that our team followed, and help you get started."

Case Studies, Tools, and Resources

The following materials reinforce strategies for spread and celebrating success.

- AHRQ Impact Case Study: New Jersey Hospital Uses AHRQ Toolkit To Reduce Urinary Tract Infections
    - This Impact Case Study highlights how ICU nurses and others participated in a quality improvement project to sustain CAUTI prevention efforts.
- "Spread" Module, AHRQ CUSP Toolkit
    - This module lays out a framework for facilitating spread of a quality improvement project.
- A Model for Sustaining and Spreading Safety Interventions, AHRQ Toolkit for Reducing CAUTI in Hospitals
    - A guide that describes how teams can sustain patient safety projects.

References

1. Hagg HW, Workman-Germann J, Flanagan M, et al. Implementation of Systems Redesign: Approaches to Spread and Sustain Adoption. In: Henriksen K, Battles JB, Keyes MA, et al., eds. Advances in Patient Safety: New Directions and Alternative Approaches. Vol. 2: Culture and Redesign. Rockville, MD: Agency for Healthcare Research and Quality; August 2008. https://www.ncbi.nlm.nih.gov/books/NBK43727/. Accessed October. 25, 2021.
2. Jeffcott S. The Spread and Sustainability of Quality Improvement in Healthcare. Prepared by Healthcare Improvement Scotland. NHS Scotland Quality Improvement Hub; June 2014. https://qi.elft.nhs.uk/wp-content/uploads/2015/05/the-spread-and-sustainability-ofquality-improvement-in-healthcare-pdf.pdf. Accessed October 25, 2021.
3. Plan-Do-Study-Act (PDSA) Worksheet. Institute for Healthcare Improvement, Cambridge, MA. http://www.ihi.org/resources/Pages/Tools/PlanDoStudyActWorksheet.aspx. Accessed October 25, 2021.

AHRQ Pub. No. 17(22)-0019
April 2022