**On the CUSP: Stop CAUTI in ICU
June 10 ICU Content Call**

Chelsea: Excuse me, everyone. We now have all of our speakers in conference. Please be aware that each of your lines is in a listen only mode. At the conclusion of today's presentation, we will open the floor for questions. At that time, instructions will be given as to the procedure to follow if you would like to ask a question. I would now like to turn the conference over to Ms. Anna [Wochiek 00:19]. Ms. Wochiek, you may begin.

Anna: Great, thank you Chelsea. Welcome everyone, to the June National Content Webinar for the On the CUSP: Stop CAUTI in ICU Project. Today we'll be talking about engaging the nurse, physician, patient, and family, as well as the CUSP topic for the month on the Learning From Feedback Tool. A quick reminder as always, to fill out the evaluation at the end of the webinar. We really value your feedback and use it to plan further content.

 Today's presenters will be [Jenny Tuttle 00:51], who is clinical nurse leader at the Tucson Medical Center in Tucson, Arizona. We also have Dr. [Kristin Cole 00:57], an assistant professor at the Feinberg School of Medicine in Chicago, Illinois. We also have [Sue Collier 01:03], a clinical content development lead here at the Health Research and Educational Trust. Finally, we have [Emily Pizzola 01:11], who is our clinical nurse leader at St. Joseph Mercy Hospital in Ann Arbor, Michigan.

 Before I turn it over to our speakers, just a quick reminder about the platform. All of the materials can be downloaded in the materials box in the bottom right hand corner, and that includes the slides and a case study we will be discussing today. You can use the chat box on the left hand side there to post any questions, but please remember that we'll have a dedicated audio Q and A time at the end of the webinar. With that, I'll turn it over to Sue Collier.

Sue: Thank you, Anna. I'd like to frame our webinar today with just a few learning objectives and we'll ground the content you're going to hear today by starting out with a case study that will give you a sense of how we can begin to think about the work that we're doing at the unit level and how it engages all of the team members. At the completion of this session, we will ask that participants be able define nurse, physician, and patient and family engagement, and as a part of that definition, be able to list the benefits and examples of how engaging key team members as partners can be a key strategy reducing CAUTI in the ICU. Last but not least, we'll hear from Emily, who will help us identify some of the key elements of the CUSP Learning from Defects Tool and how this process as well can be used to improve performance.

 Let's ground our work today by presenting first a case study that will hopefully give you some context as we begin to have conversation concerning engaging key members of the team. In our case study, Mrs. C is 66-year-old female who was in the OR for an exploratory laparotomy. An indwelling urinary catheter was inserted in the OR, and the patient was transferred to the ICU post-op. The nurse in the OR gave her port to the nurse in the ICU. The next day the patient is stable, and the indwelling urinary catheter is still in place. Mrs. C's son has been with her since surgery, but he's not been included in any rounds with the nurses or the physicians, because they occur outside of visiting hours. Daily rounds and morning huddles did not include assessment of the indwelling catheter.

 By the next day, Mrs. C is febrile at 38.9 Celsius and she complains of diffuse abdominal pain. Her white blood cell count has increased, and she has a cloudy, foul-smelling urine, and a urinalysis that shows positive for protein, nitrates, leukocytes, as well as white blood cell count and bacteria. Her urine culture is showing E. coli and her abdominal pain seems localized to the surgical area. That same day, Mrs. C is diagnosed with a CAUTI by the attending physician, and the physician orders a course of antibiotics. But during the morning huddle, the infection preventionist reviewed the prevalence of urinary catheter use in the ICU, and several staff indicated that a higher prevalence of UTI in the ICU is not unusual. When Mrs. C's son was at the bedside during visiting hours, he stated he was angry and concerned that his mother had an infection.

 As you think about how this case study grounds our conversation today, think about three elements that really impact engagement of each of the roles we're going to be reviewing today: The nurse, the physician, as well as the patient and the family.

 First of all, what are the concerns and fears? What might be some of the unique issues that each of these roles has relative to urinary catheters or CAUTIs? Ask what do they need to know? What are the skills and the knowledge that will help them, not only adapt or adopt new practices, but to be confident that it's the right thing do. This could include communication skills as well as information and education. Then last but not least, what are the system support elements that are in place, and what can the system do to promote evidence-based practice in a culture of safety? This could include things like policies and protocols, as well as checklists and any initiatives designed to improve how the team worked as a consolidated group.

 With that case study as the grounds for our conversation and with these three elements in mind, let me turn it over to Jenny, who's going to talk about nurse engagement in the ICU. Jenny?

Jenny: Thank you, Sue. Yes, my name is Jenny Tuttle. I'm the clinical nurse leader at Tucson Medical Center in the ICU. We do everything but hearts, basically. So as you see, we're neuro, surgical, medical, a very busy high acuity unit. Part of why I've been asked to speak here is because I was a leader for this particular project at my hospital in late 2012-2013. They've asked me to talk about nursing engagement.

 Just a few slides, we've got a lot to fill in today, so I'll try and keep it short and sweet. Some of these you guys have certainly already addressed, but just to back up. The biggest thing I've found with nursing engagement, and I actually identify my own deficit, I could have done a little bit better job when I did this, but it's the education of staff as laying that groundwork and explain to them the purpose, expectations, the who's, the what's, the where's and the when's.

 As far as who, the case studies, I think if you can bring in case studies that are very pertinent, happened on your unit, that will have more meaning for them. We have for example, our director of infection control, her mother died from complications of a CAUTI, and that's something she was able to share with us. It hit home a little bit more when you can really make it something tangible for the nurses. Obviously, you want to review your current unit data, what's driving the reason for doing a CAUTI project. We at the time had the worst CAUTI rates in the hospital.

 What do we expect of these nurses? Making very clear goals. We actually with the CUSP project, our goal was reduction by 25% in our CAUTI rate, when in reality our PMC, our real goal, was a 40% reduction. We had a couple of goals, but they were very clear. What types of protocols do you have? Do you already have them there? Do they need to be tweaked? We were fortunate, again, 2012-2013, a lot of protocols weren't out there, but we actually already had one, but we were able to tweak it and guide it with a little bit more of the HICPAC guidelines versus we had some pretty general reasons to have a catheter, and we found every excuse we could under the sun as a nurse to have a reason to keep one. We changed those, tweaked our protocols, and educated the nurses on those. And again, what are the expectations when discussing CAUTI? The expectations being in your huddles you’re talking about it, your bedside report nurse-to-nurse, you're talking about catheters, tubes and drains.

 Where are you doing your project? We started ours on our 450s unit, which is the ICU versus the CCU, because we had the worst rates, and then we expanded it to the whole department including the CCU. Figuring out where exactly you're having this, and then we ended up rolling it house-wide, so just nailing down where it is you doing all the project work. When? Certainly with physician rounding, we would bring up the tubes and lines, and even then we still have to remind them to do that.

 The other big thing is, every shift is important. I can tell you my champion, nurse champions at night, were great. It's not just a day issue, this is a night issue, and they really have made and effort to get those Foleys out at night as well. It doesn't happen to be just a day issue. So really, the expectation is every shift is responsible. And certainly why, at the end of the day, why are doing this? We need to provide them the stats for improvement, or where we need to show improvement, and of course we know about the harm this can cause and the cost. At the end of the day, it is a lack of reimbursement, but most importantly, it's the harm we can cause our patients.

 As we all know, there's plenty of education out there to help our nurses better understand why we're doing this. I have my facts right there, that the estimated 13,000 deaths annually are attributed to urinary tract infections. At the end of the day too, we found out, because our infection control department really facilitated a lot of this many years ago, but it never caught on, at the end of the day, what it boils down to is nursing owns this. We put the catheters in, we take the catheters out. We have to sometimes remind the physicians. So the nurses have to own this, and that's where we really made some bigger impact, is when nursing took hold of it and tried to make changes.

 Next is providing the tools to succeed. I can tell you, many times, I've been an ICU nurse for 26 years and in leadership more in the last five years. Oftentimes I was in a staff meeting and I'd get the, you know, our CLABSI rates are this, our CAUTI rates are this, MRSA, you guys need to get those down. But we were never given, they were just told to do it, but were never told how to do it. Look at what you have as far as tools for your nurses to get this done. By giving them the tools, you're going to engage them to help those rates go down.

 Certainly review your current supplies. We found we had one condom cath size only, we expanded that. We've expanded to better chucks, putting in chucks that wick, because we also work with the pressure ulcer department, our walk nurses to reduce those, and make sure that that wasn't going to affect them. Listen and identify opportunities to make workflow easier. Listen to those nurses, because as we all know, you're taking these catheters out which at the end of the day, if you can reduce re-utilization, you're going to reduce your CAUTI rates. We saw that time and time again. What can we do to make their life a little easier if we can? Some hospitals, I was reading last week out of Medscape, a New York hospital, they were able to bring in extra techs. Not all of us have that luxury, so what else can we do? Listen to your nurses, they have some great ideas too and we've had some great ideas on our end here.

 Again, give staff an opportunity to be a part of decision making. Sometimes you can't always do that, you just need to make a decision as a leader, a manager, infection control person, physician, but if you can, and sometimes just bringing those little decisions can help them feel more engaged in the process, and that they're a part of it, and not being told what to do. As we know, sometimes it costs more in supplies, but every CAUTI not only costs money but can risk a life. Our administration was willing to pay the extra things for certain devices, external devices, premium chucks, and all those things, because you know at the end of the day, it's the patients that are going to benefit from this.

 Reminders will always help. We have some posters up. We worked with one of our [HEN 12:04] groups, and they gave us posters. We were able to put them up, reminding of the HICPAC guidelines, why we're taking out catheters. There were certainly t-shirts. Again this New York hospital, they had Friday Foley, so on Fridays they all wore t-shirts to remind people that Foleys need to come out. Slogans, what you can come up with. We were creative, some not always clean, I won't say some of them, but whatever it takes for you to remind nurses, get it out there, and have them thinking about it. And certainly computer-based assessments. Like I said, we had a protocol in place in our EMR that the nurses had to fill out every shift, but it was very loose. We ended up narrowing that down to the HICPAC guidelines, and our infection control department audits those, so it allows us to see which nurses are really using it, and hopefully it's reminding them to take those catheters out.

 Next is certainly making staff accountable. We can tell them to do these things, but unfortunately as much as we hate to do audits, you still have to look at who's doing it, and do they need to have a little chit chat. Auditing and surveying, asking open questions. I did find when I was auditing my nurses or going around, "Hey, why are we having this Foley today?" And I'll get my reasons, and they can give me legitimate reasons. If they hemmed and hawed, I would start open-ended questions. "Well, let's see, if you don't have a reason, let's consider taking it out." I had nurses say, "Well, you know, but you know, they have Lasix," and I'm like, "Not good enough unless it's acute." At the end of the day, I had to kind of push them a little bit, and say, "Okay, well let's just take the catheter out because we do have the protocols in place." You have the opportunity to track them. If we need to, we can put the Foley back, but we never gave them a chance to be continent, so let's take it out and let's see what they can do.

 We found that more people can tolerate having the catheter out and do fine. Of course, we all have bladder scanners anymore, that's a tool of the trade we all have to have. Open questions, just don't settle with the answer of well, they need it. No, tell me why they need it, and say, "Why don't we think about taking it out, what would be the worst thing that could happen?" Nursing-based, again back to if all else fails, we take it out, we can fall back on our nursing-based urinary insertion removal protocol. So, are they using it?

 Last is accountability, is providing that current data. We had a big bulletin board and what I ended up doing at the end of the day was, we had done great. We started having a few more CAUTIs back up, so on the big board I broke my two units, this was when we combined both of our ICUs to look at CAUTI rates. So I broke it down to ICU and CCU, and said okay, here's a CAUTI. I write the name, and the date, and this is a lockable room, it wasn't a HIPAA violation, but I was able to say hey, let's talk about this person in the huddle. They said, they got a CAUTI. Putting a name with a date and the nurses having to talk about it, it made them more accountable and it's like, "Oh, gosh, I didn't realize they got one." You need to work on that. Certainly unit newsletters to just get that information out to staff.

 Lastly, it's acknowledging the successes. We can't afford to give them a gift card to Target every day just for taking a Foley out, but I was able to piggyback on another program we had here at TMC, which is the Culture Change. For example, I was able to give out little plastic coins which got them a soda or a cookie at the cafeteria. It's not much, but I was finding nurses were coming up to me and saying, hey I got my Foley out, can I have my change? Sure enough, I was more than happy to give those out. It changed the culture there, and it had them thinking about getting the catheters out. Even now, even though I don't use that change any more, because like I said we did this 2013, I still have an occasional nurse come up to me and say hey, "You be proud of me, I got my catheter out." I'd high-five them. Just the little things, it doesn't take much.

 Again, this article, I liked this article I read last week from North Shore University Hospital, New York. They had a really great idea, and again it's something that makes it more visual for nurses. They had a sunflower. What they did, is they added a leaf for every day they were without a CAUTI. I think that's a great visual reminder and the ability to show the success of that unit. Those are the areas I think are primary in getting nurses engaged in my unit.

 Just one thing, when I looked at the case study, just from the nursing side, the thing that jumped out at me was, number one, and it's kind of a side note, but the visiting hours. We've gone to 24/7 visiting hours years ago, which allows the family to be there when they want to be, at change of shift, and we let them be a part of the bedside report, so there they can hear and understand what we're doing. That's something I would probably consider based on this case study. Certainly daily rounding, that's where they can also, hopefully, be in making sure that the physicians are talking about their catheters and maybe be a part of that conversation.

 I didn't see protocols to remove this. It's interesting, this case study hit home for me. I had a patient who was post-op day one, abdominal surgery, exact same case scenario, so we withdrew that catheter on post-op day one. We took it out, because it met the criteria. The patient was awake, alert, able to void on his own. Then I had a surgeon come back later in the afternoon who was not very happy that we took that catheter out. In fact, he made us put it back in. I'm sure Dr. Cole will be addressing how talk to physicians. Our intensivists are on board, but not all of our surgeons, so hopefully we'll get some help in figuring out how to address the physician issue.

 Judging from the criteria of this case study, this looks like an insertion issue and again that falls back on nursing. This is something that was CAUTI caused due to insertion since it was 48 hours later, or within 48 hours. Those are some of the things I identified in the case study, and I'm sure you guys can see a bit more. Thank you for time and I'll let Dr. Cole take over next.

Dr. Cole: Okay, thank you Jenny. Let me just preface this portion by saying that I do have a lot of slides which I will go through quickly in the interest of time, but I wanted to provide the full set so that you can peruse them at your leisure later. Next slide. Our agenda for this segment will be to define physician engagement, understand the scope of it with respect to the CAUTI project, identify the challenges, look at the solutions both general and specific, and then finally synthesize all of the information and distill it into a summary for easy reference. Next slide.

 There's no one universally accepted definition of engagement, but one that we can use as a starting point is that it is an intentional and deliberate process to bring physicians and other stakeholders together to address problems continuously and to improve care and the patient experience. Next slide. Another way to look at it, is that when physicians are engaged, they invest their time, demonstrate curiosity, show enthusiasm, contribute in various ways, and then begin to influence others to their way of thinking and behaving. Next slide.

 So why does it matter? The evidence [inaudible 00:19:02] suggests when physicians are engaged that is linked with better outcomes, and greater success in quality projects. Next slide. Now let's look at the scope of physician engagement. There are 3 main types of physician stakeholders in the context of this project. The first is the medical executive, and this could consist of physicians who may be CMOs, CQOs, BPMA, et cetera, as well as medical executive committee members such as the Chair of Medicine and Surgery. Then we have the physician champion, so of course, the doctor with who you'll work most closely within this project, and they can be a hospitalist, ID physician, urologist. The third group are the individual clinicians, and we'll divide them into the non-surgeons and surgeons, and more to come on this particular taxonomy later in the presentation. Next slide.

 Why is it so challenging to obtain engagement? Next slide, oh I'm sorry, that's the correct slide. Several reasons, first, is that organizations likely have different goals and incentives from physicians. They may actually be in competition with one another. Second is the physician culture can also be a barrier. Doctors are trained to be autonomous and independent rather than team oriented, and there's always concerns about medical legal implications behind every decision that's made about a patient. Third, the work life and work toll of physicians is another challenge. They have limited time, can attend at several hospitals, and may not have a particular loyalty to any one hospital. A lot of physicians are not aware of quality and safety projects, so really more focus on that individual patient, not so much on systems. Many don't have the QI skills, or the language, or the concepts. Next slide.

 Now we'll look at solutions, we'll start with the general and then move to some more specific and practical solutions. The 3 general approaches include, first, the 6 drivers as identified in a study of 10 of the best health care systems in the US, the IHI framework which also has 6 elements, and then, of course, the CUSP model with the 4 Es. As we talk about each one we'll be moving from how to get collective engagement of physicians to more individual. Next slide.

 This was a study conducted some Harvard researchers on the 10 best US health care systems. They identified 6 drivers for strong engagement. The first was to have engaged leadership. The second was to have a physician compact, and a compact is basically just the rules of engagement and the expectations for physicians and the institution. The next driver was appropriate compensation, the fourth driver was [inaudible 00:21:34] based financial incentives. At academic institutions promotion was also a driver. Finally, there was the data and enablers. By any of those we mean the processes and tools that enable physicians to take action to improve care such as the electronic reminders, clinical guidelines, and protocols. Next slide.

 The IHI also with some of the best health care systems in the US, including Mayo, they also looked at the British National Healthcare System, and came up with a framework for engaging physicians in quality and safety. They also had 6 elements in their approach. The first was to discover a common purpose. Secondly to reframe values and beliefs, third was to segment the engagement plan. Fourth was to use engaging improvement methods. Five was to show courage, and six was to adopt an engaging style. Now let's look at each one a little bit more closely. Next slide.

 For the first element it's to discover a common purpose or shared vision, both hospitals and physicians want to have good patient outcomes, they both want improved efficiency and decreased wasted time. They both have professional pride and want to have an excellent reputation, and for some physicians in hospitals, who are perhaps more self-actualized, it may be about contributing to a cause greater than themselves. Hospital leaders should provide an exciting organization vision to really engage physicians at the highest level, and help them to feel that they're contributing their time and energy to something great and worthy. Next slide.

 The second element is about reframing values and beliefs. Rather than seeing physicians as customers they should be ... Excuse me, viewed as partners, the only customer, really, should be the patient. Of course this requires a change in beliefs and attitudes. Next slide. The third element is to use segmentation, which is to more or less divide and conquer. Work with your physicians to see who you should focus on to get the most optimal results. Apply the Pareto Principle, which is also known as the 80-20 rule, and in this context it is essentially about focusing on the right 20% of the physicians to get 80% of your results. Next slide.

 The fourth element is to use engaging improvement methods, physicians are scientists and they respond to data. Show them that data for feedback purposes and do it in a rapid cycle to generate momentum. No physician likes to be a data outlier, unless it's in a good way. Use the data sensibly to generate awareness and enlightenment, not to inflame or for punitive purposes. Show evidence based guidelines if needed. Next slide. Next, show courage. Any improvement will require that people change, and that may not be taken well by those who are comfortable with the status quo. Have a belief in what you're doing. There should be backup for you, all the way to the hospital board. Next slide.

 Last element is to adopt an engaging style, and this is about involving physicians from the beginning, in the plans, designs, and decision making process. Not only with those who are enthusiastic, but also invite the critics, you'll get to hear what a potential pitfall may be that you've never thought of, and get a better outcome. At least once they've expressed their concerns, while you may not get full embracement, there's probably less chance of getting undermined in the future. Next build trust one project at a time, communicate often and regularly, and value their time by scheduling meetings when they're most available.

 Next we'll segway into the CUSP Model's 4 Es for engaging physicians. I think that it will compliment this last point from the IHI framework well about adopting an engaging style. Next slide. The 4 Es in basic model will assist in identifying and engaging physicians, or others, to your team. It was created by the John's Hopkins Quality and Safety Group, and has 4 elements. The first is to engage, and this is about answering the question of how does this make the world, or ICU, a better place? This work is really the adaptive work, where the unit teams helps staff understand the results of the CAUTI. They can do it by sharing stories, or estimating the number of patients who were harmed. By emphasizing this sort of involvement it not only helps with the success, but the sustainability of the effort.

 The second E is to educate. It's about what do we need to know. It involved educating the staff and senior leaders so that they understand what their roles and responsibilities are with the CAUTI project. The third E is about execution. It's what do we need to do, this also involves adaptive work, and it's good, the unit teams apply a plan of action based on the units resources and culture, and then analyze their roles within that plan. The final E is to evaluate. It's how do we know that we've actually done any good. This is about where the unit teams collect and submit data to analyze the success of their efforts. Next slide.

 Now we're going to discuss some more specific solutions for obtaining engagement from the particular physician stakeholders. Again our stakeholders, as mentioned, are the executives, the champions, and the individual MGs. Next slide. Within the medical executives and the MEC, consider doing a cultural assessment to get a temperature of ultimately how easy or difficult this new project could be. There is a tool, by the IHI, that had 7 questions that you can use to kind of gauge that temperature. When you're reading for the next step present data on CAUTI initially and regularly to the MEC. To really get their attention present on the business case for CAUTI prevention. There is a cost calculator on the website Catheter Out, and a CAUTI can increase [inaudible 00:27:13] stay by 2 days. That can mean a lot in the eyes of an executive, or in administration if you can reduce a stay by 2 days. Also discuss the CMS policy for non-reimbursement of CAUTI. Next slide.

 In choosing the champion pick one who is respected, courageous, sociable, has good communication skills, is intrinsically motivated, and really any clinician who is interested in quality and safety. Don't choose someone who is a full time physician administrator. Your champion needs to have that street credibility, so to speak. Next slide. The responsibilities of the champion will be to communicate with other physicians about the project, educate the medical staff on the indications, assist with process development, assist with implementation of the components, and then help to remove the physician barriers. This is probably the true test of that physician champion, is when he or she encounters that resistant physician. Next slide.

 Once you've recruited your champion, some additional things to equip and support them in this role. First is provide them with the material, consider an electronic information packet, so that they can get up to speed on the technical and adaptive components. Have them connect with their executive sponsors so they know they've got back up when it's needed. Connect them with other physicians who are the early adopters who can support them. Have a communication plan, and then consider some sort of recognition as a gesture that you value their time and contribution. Next slide.

 This is a sample script that can be used by your champion, or nurse champion, for that resistant physician. It's adapted from the IHI, and I think it challenges that resistant physician to try and change, but not in an overbearing or inflammatory type of way. Next slide. Some more tips and techniques to get engagement on individual physician model. These are arranged, to some degree, on difficulty of buy in, so that the further down the list are the tactics for the most [inaudible 00:29:08].

 First, and very importantly, make it as easy as possible to do the right thing. Have automatic stopovers on Foleys. Involve physicians early in the design and planning, have your champion present at meetings, provide data and feedback to the outliers, as well as those who doing well for positive reinforcement. Appeal to profession pride to the data, engage medical leadership support. Use scripts to explain the rational and to engage, and then frame it as to why they should care or be involved. For the [inaudible 00:29:40] have one on one education, listen carefully to the resistors, and then ask them directly if they still resistant, "What would take for you to participate or be involved?" Then consider rewards and recognition, later, for those who deserve it. Next slide.

 We'll turn to that last group of physicians, the surgeons. This is a slide from Doctor Sanjay Singh. Surgeons, as a group in general, they're very tribal, and they'll listen to someone they consider to be their peer, which is basically another surgeon. The bottom line in overcoming resistance from this group is to have another surgeon on your team. Next slide. We looked at solutions, but we should also touch on briefly what not to do. Don't use inflammatory language, be careful the messages and the messengers that are sent, don't adopt a one size fits all mindset as culture and resources vary for each unit. Don't just use education as your sole means, that's been found to be ineffective. However, to use education combined with another mechanism such as reminders. As Winston Churchill famously said, "Never, never, give up." Next slide.

 Let's put all this information and pieces together. Next slide. This is a scenario solution summary adapted from the website Catheter Out, it can be used for quick reference as to the type of physician you have and the problems, scenarios, you are experiencing with suggestions on how to address the problem. Look at solutions both general and specific, there is some overlap between the 2 categories. If you see something in the general approach that could be applied to an individual physician, and vice versa, by all means go ahead and use it. Bottom line is to tailor your approach so that it's appropriate for your culture and resources. Next slide.

 Thank you so much for your attention.

Sue: Thank you so much Doctor [inaudible 00:31:35] really a great overview of different strategies that be used to engage physicians. I want to close out this portion of the webinar while talking about patients and family engagements. This is really going to be a very [inaudible 00:31:48] overview to give you a definition of patient and family engagement because all grounded in the same perspective. Also to give you some benefits and examples to engaging patients and families as partners in reducing CAUTI in the ICU.

 Now we talked earlier in the webinar about these 3 elements. Concerns and fears, skills and knowledge, and system support. Each of these areas have relevance. When we think about the patient and their family, when we think about concerns and fears, obviously, one of the concerns is the risk of infection. Especially if it relates to invasive catheters. In terms of skills and knowledge, patients and families really want to understand what they need to do to be part of the team, how they can be involved in rounds, as Jenny mentioned. Having bed side shift report, with the family members engaged, is a great way to be sure that we're addressing their concerns, but they want to understand skills and knowledge they need in order to be engaged in the care of the patient. In terms of system support it's important to ask, "When is your system due?" To promote patient and family engagement. Are patients and families included in [inaudible 00:33:01] that are focused on safety issues. Are they getting access to the checklist, or the teamwork practices that you engage in your particular ICU. Then do you have family presence policies? All of these elements have a key message, and that's that patients, and their family members, can effectively impact outcomes by understanding and supporting the evidence based practices, and really, truly, engaging with other team members to adopt these practices.

 Let's talk about our definition of patient and family engagement. There are many in literature but we'll go with the one that [Crystal Carmen 00:33:40] had in the Health Affairs Journal several years ago. It's really defined as patient, families, their representatives, and health professionals, working an active partnership at various levels across the health care system. This could involve at the bedside, at the organization level, as well as at the policy level, but the purpose of this engagement is to improve health and health care. Much like physician engagement, it is intentional and deliberate, and it's with the nursing engagement. Everyone wants to have an opportunity to be part of the decision making process, so we have a shared purpose in terms of engaging all team members, especially the patient and family.

 When we think about the evidence it's clear, there's evolving evidence, but there is research that's emerging that shows that patient and family engagement translates into improvements, primarily in the areas of safety and effectiveness. We know that we still need to do research that translates what are the specific mechanisms that connect patient and family engagement with outcomes, but this evidence is evolving every day. Ultimately, in order for us to create the opportunity for patient and family engagement, we must create the environment. The first step to insuring patient engagement in the ICU, or any setting, is to really have a culture that promotes and sustains those core principles that involve dignity and respect, information sharing, as well as participation and collaboration. This involves developing mutual respect for the skills and knowledge that the patients and families bring to the table, having honest, clear, and two way communication that's transparent, especially as relates to knowledge and information around their care.

 Demonstrating, understanding and empathy by being accessible and responsive to their needs, and having mutually agreed upon goals that really are evident that you have a shared decision making model. It's about doing things with patients and families not for or to them. It's important for us to note that there's a cascade effect of shared decision making. We know that patients [inaudible 00:35:58] care hinges on having shared decisions, but when we have shared decision making this means that the process of support informs patients. Informed patients can make better choices, and communicate more effectively with providers, that open communication promotes efficiency, reduces waste, and supports evidence based care. Ultimately what the research is shown is that informed patients often prefer lower cost and less intensive treatments. It's really about building an environment that enhances trust, it engages the patient and the families from the beginning, and then includes them when you're setting goals and expectations.

 This slide shows a few examples of patients having engagement, that we've seen evidence in high performers, in terms of patient engagement in the ICU. Jenny already mentioned including patients and families in bedside shift reporting rounds. Also supporting family presence, it's important that we recognize that family members are not visitors, they are family, and that we create an environment that allows the family to be present so they can be active participants in their loved ones care. Including patients and families in the CAUTI prevention education, having them actually part of the education and training. Maybe a patient has had a catheter, or a family member who has worked with a loved one that had a catheter associated UTI. Or sharing patient stories in quality team meetings, these are ways that we bring reality to the numbers, and to the dashboard, and to the checklist, that we're using to prevent CAUTI.

 Many organizations are developing patient-family advisor roles and councils, and by doing so they are engaging patients and families in ways that are very meaningful, very intentional, and if you're system, or your organization, does indeed have patient-family advisors, encourage them to serve on your quality and safety performance improvement teams. Many organizations have the substantial benefits from having the voice of the patient at the table when discussing things like the efforts to reduce infections in the ICU.

 I think it's also important for leaders in the ICU that are on the clock today to recognize that your professional organizations have supported many patient-family engagement initiatives. The Society of Critical Care Medicine, as well as The American Association of Critical Nurses, each have a number of different programs that are designed to really elevate the topic of patient and family engagement, and to demonstrate that this is a priority in, not only the industry, and in this area of practice, but it also provides many resources and tools that you may find useful if you are trying to advance patient and family engagement in your ICU.

 It's very important that as a part of this program you ask yourself a few questions. That includes, how is your organization demonstrating the principles and practices of patient and family engagement? What are some of the things that you're doing, now, to engage patients and infection prevention, specifically in CAUTI prevention? What are some of your organizations long term plans to advance patient and family centered care across all areas of patient safety, especially in CAUTI? Also ask if you have someone who is leading or guiding your unit, or organization's efforts in this area, ask to be a part of the program.

 We've included in the slide [inaudible 00:39:42] today some selected resources that provides some very specific, and detailed, examples of how you can engage patients and families as partners in safety. I'm going to turn it over to Emily Pasola who is going to share with us the tool, learning from a defect. Thank you.

Emily: Hi this is Emily. When we're talking about a culture of safety, we're talking about one that is supposed to be safe for patients, their families, as well as staff. Part of establishing a safety culture requires that we have an atmosphere where we look at defects or errors as problems with systems. The definition of a defect being that it is anything that anyone does not want to happen again. It really is identifying opportunities to make the work environment safer for everyone. Strategies to identify defects include finding themes among event reporting, or common reasons for root cause analysis, or sentinel events, and then also things like monthly data reports that identify recurring gaps, or outcomes, that aren't quite reaching a specific target.

 In my own experience, I think that a great way to help identify defects within your work environment is directly through frontline staff. Things like daily shift huddles are an open forum to discuss unit successes, as well as talk about safety concerns that staff might have. Staff meetings, they're another way to engage staff in the discussion about safety concerns, and last, what in my opinion the ultimate best way, is by administering the staff safety assessment. The staff safety assessment is an anonymous approach, it doesn't have to be anonymous, but I can be an anonymous approach to getting direct feedback from staff about patient harm. It asks 2 questions. How is the patient? How do you think a [inaudible 00:41:38] patient in our unit is going to be harmed? How do you think that we can prevent that harm from occurring? This survey really embodies the core CUSP principles of respecting the wisdom and observations of the front line staff member.

 The process of identifying and learning from defects has to be a balanced mix of both technical and adaptive work. The tool itself is very quick and efficient, it helps keep the conversation on track by organizing action plans to address whatever defect that has been identified. Again, the most important component of this process is that if focuses on what went wrong not who did something wrong. This approach can help allow front line staff to take ownership of defects that occur in their unit, and also collaborate with other members of the multi-disciplinary team, including some people that they may not have an opportunity to directly work with in normal day to day environment. The tool allows for a more effective communication, it provides structure around problem solving, using key words at key times.

 For example, each CAUTI could be treated like a defect. In addressing the adaptive work, the goal would be to engage the staff who are directly involved in patient care to work as a team. Collaborating, evaluating their current practices that they know are, or are not, happening, in order to identify the barriers to reaching their target of no CAUTI. The group may brainstorm different ideas, all while being able to look at the defect through the eyes of others. As a result they might come up with, and create, tools and other types of checks and balances that can address problems with current practice related to CAUTI. Things like checklists or tools to decrease variation in practice, that becomes part of our technical work, and can help standardize the care process to help prevent a defect in the future. Through engaging team members, though, to become part of the change, that's where we're really building positive relationships through developing common goals and really promoting a culture of safety. This adaptive work, that is our CUSP work.

 I'm sorry, I need to go back one. Here is an example of a badge card that runs through the structure of the learn from a defect process. It talks about what happened, a brief description of a defect. Why did it happen? It focuses on contributing factors, and it lists examples there of factors. We ask via team, what can we do to reduce the risk of this happening again to another patient? How are we going to know this risk was reduced? Who are we going to share our learning with? Yesterday, actually, we did a learn from a defect during our daily shift huddle on day shift. It took about, maybe, 7 minutes to discuss a defect we had found during inter-disciplinary labs from one of our cardiothoracic surgery patients. The defect was that a peripheral IV had remained in a patient for many days after expiration. We just discussed as a group what happened, what are we going to do to assist in preventing it from happening to another patient.

 We want to know what those contributing factors are. What was going on over those past few shifts prior to yesterday that may have been factors in why it was missed? The frontline staff, they're really who walk the walk, and they really have the expertise and the knowledge needed to improve safety. I learned from a defect process often takes the pressure off of staff feeling like they're targeted for individual performance.

 Now I'd like to just go through 2 other specific examples. This first example, this is using the learn from a defect template that we use here at Saint Joe's. It's from about a year ago, it included working with many different members of the multi-disciplinary team, across several departments that included the surgical ICU, the OR, and the anesthesia department. A patient was admitted to our unit with a nitroglycerin bag hanging on a pump that was programmed to be [inaudible 00:45:56]. When a defect like this happens we want to correct what we can right away to prevent immediate harm from reaching the patient. Then we also want to take a step back and look how we can improve the process, and in this case it was the hand-off process, or a double check process, to ensure that this doesn't happen again.

 We determined that there were both people and process factors involved, and during our learn from a defect discussion one of the anesthesiologists identified that often before they leave the OR with patients, some of the IV pumps can malfunction causing them to have to move critical medications from pump to pump in order to keep them going. The anesthesiologist in this case absolutely had no intention of this error occurring, but we identified other contributing factors that helped make this error reach the patient. There were too many people in the room, too many people doing too much, and no one was taking charge of what had been done, and what needed to be done. We also discussed what helped the defect from being worse.

 In this case the error was caught several minutes after the patient was admitted, and we identified that we already had a few good processes in place, but they just needed some fine tuning, and modification, to help prevent the drift that was taking place, and help bring the group back together and remind us of the why behind the standardized process. Why we were doing that standardized hand-off process. The big change for this defect is that when a patient is rolled into the unit from the OR, the anesthesiologist and the admitting nurse touch each bag immediately matching it to its pump to double check correct dosing. This takes place even prior to any discussion of what went on in the OR.

 The final step in the learn from a defect is sharing action plan with those affected by the change. We're very transparent here with our action plans, and we're able to do a lot of this during our daily shift huddles, during reminders prior to patients being admitted to the unit, and even just through direct communication, one on one.

 This second example was from a few weeks ago after a patient fall. I realize it's a little bit blurry, but the reason why I thought this would be a great example is because it provides an avenue for patient and family input as well. This is our super falls huddle form, and it follows the learn from a defect structure. Again, identifying what happened, why it happened, contributing factors, and how we're going to try to prevent it from happening to another patient. These learn from a defect, or super falls huddles, take place very quickly after a fall. This one took about 10 minutes, so this process is pretty quick. In this case the patient did already have some fall prevention tactics in place, but we did identify some opportunities where we could have done better for this patient.

 The nurse talked about how we needed to include bed alarm checks as part of our bedside hand-off process. I thought that this was a great idea, and something that we hadn't thought about before. She truly felt that if they would have checked it during hand-off, they would have caught that the bed alarm wasn't on, and it could have made a huge difference for this patient. We also had the opportunity to talk to the patient, who did say that they had their call aid but forgot to use it, and needed to get up to go to the bathroom. What this feedback identified was that maybe this patient needed more frequent [inaudible 00:49:33] and more specific reinforcement for using their call aid.

 You see that we use the learn from a defect process here for many different situations. I really hope that you found them helpful, and I'll be open to questions later. Thank you.

Chelsea: Great, thank you very much Emily, and thank you to all of our presenters for those really, really, informative, presentations. I'll go ahead and ... I'll go ahead and just review some next steps. I'm sorry Emily, did I cut you off?

Emily: No you're good.

Chelsea: Oh okay good. Just some next steps for you as you're wrapping up here. You can assess your ICU's level of engagement of nurses, physicians, and patients and families. Think about are there opportunities for improvement? What are the barriers that you are facing and how can you utilize some of the tools presented here today? Including the tools presented by Emily and the learning from defects, as well as the case study that Sue presented earlier. Finally you can review the concepts and tools reference to bolster your ICU's level of physician, nurse, patient, and family engagement.

 I know that Sue and Jenny are having a great conversation in the chat box, I encourage you to post questions there. I'll also ask our operator to open up the lines for Q and A. If you're not able to stay I do really encourage you to fill out the evaluation. We really are very thankful for that feedback. I'll go ahead and open up the Q and A now.

Operator: Yes Ma'am, at this time we will open the floor for questions. If you would like to ask a question please press the star key, followed by the 1 key, on your touch tone phone now. Questions will be taken in the order in which they are received. If at any time you would like to remove yourself from the questioning queue just press star 2. Again, to ask a question, please press star 1.

Chelsea: If you're more comfortable posting a question in the chat box, please feel free to do that as well. We'll go ahead and read those out as soon as we see them posted.

Operator: We're currently waiting on questions in the queue.

Chelsea: Great, Sue did you want to say any few final words now that ... About the case study and any wrap up?

Sue: I think that the case study is really intended to just get the frame and a grounding for the conversation. I would encourage each of the participants as you go back through your individual units, and work with the staff, that you identify your own case studies, real examples, where you had opportunities to engage nurses, and physicians, as well as patients and family. More important, that you identify the things that you're doing well. You've heard a lot of information today, and I'm pretty sure that there are a number of leading performers that are on the call today. Just start with identifying those things that you're doing well as it relates to engaging key partners, and then begin to identify how do we take it to the next level. I think that's a great way to use the resources we provided to you today, and also for you to help give context to the content that we've presented.

Operator: Great, thank you for that Sue. Chelsea do we have any questions?

Chelsea: As of right now we do not.

Operator: Okay well we'll take 2 more minutes, I think, to wait for questions if anyone has them.

Chelsea: As a reminder it's star 1 to ask a question.

Operator: Thank you Chelsea. As a reminder all of the materials from today's call will be on the website early next week. That will include the recording, the slides, and the case study, and any Q and A that we get later on in the call.

Chelsea: Okay, well if there are no further questions I'd, again, like to thank all of our presenters for their time today, and for their great presentations. I will encourage, once again, all of the participants to fill out the evaluation. We ask that everyone who participated on the call fills out the evaluation. If there are multiple people who are listening in your room today, please make sure that everyone fills out an evaluation. We will talk to everyone again next month on the July call, on July 8th.

Operator: All right, thank you ladies and gentlemen. This concludes today's teleconference. You may now disconnect.