

# Can You Hear Me Now? Optimized Communication to Reduce Hospital-Acquired Central Line Bloodstream Infection (CLABSI)

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## Background

**BACKGROUND** – Effective communication that is timely, accurate, and unambiguous results in improved patient safety. Central venous catheters are the most frequent cause of healthcare-associated bloodstream infections. Central line-associated bloodstream infection (CLABSI) events increased during FY16. The hospital CLABSI improvement committee identified uncoordinated efforts of multiple disciplines simultaneously working on CLABSI reduction strategies as a significant root cause for lack of improved CLABSI performance.

**METHODS** –A unified communication strategy was created with oversight from the CLABSI improvement committee. Essential communication building blocks included standardized metrics and data display, custom improvement tools and 24/7 access to unit level performance via a “one-stop-shop” intranet site. Once the intranet site was implemented, it was used as a regular mode to deliver consistent CLABSI information to all levels of staff and leadership.

**RESULTS** – On demand access to metrics and improvement tools enabled stakeholders to have resources available regardless of time, day or shift. Continuous availability to frontline staff created hyperawareness and urgency around CLABSI prevention. Subsequently, staff were engaged and empowered to monitor and act on their own unit’s performance. Since implementing the communication strategy there has been a gradual decrease in both Standardized Infection Ratios (SIR) and Standardized Utilization Ratios (SUR). FY17 SIR of 0.80 decreased to 0.72 during FY18 and FY17 SUR of 0.98 decreased to 0.88 during FY18.

**CONCLUSIONS**- Effective communication is essential when coordinating any type of sustainable improvements. A multi-pronged communication plan around CLABSI can assist Infection Prevention with a shift towards shared ownership of unit performance.

## Methods

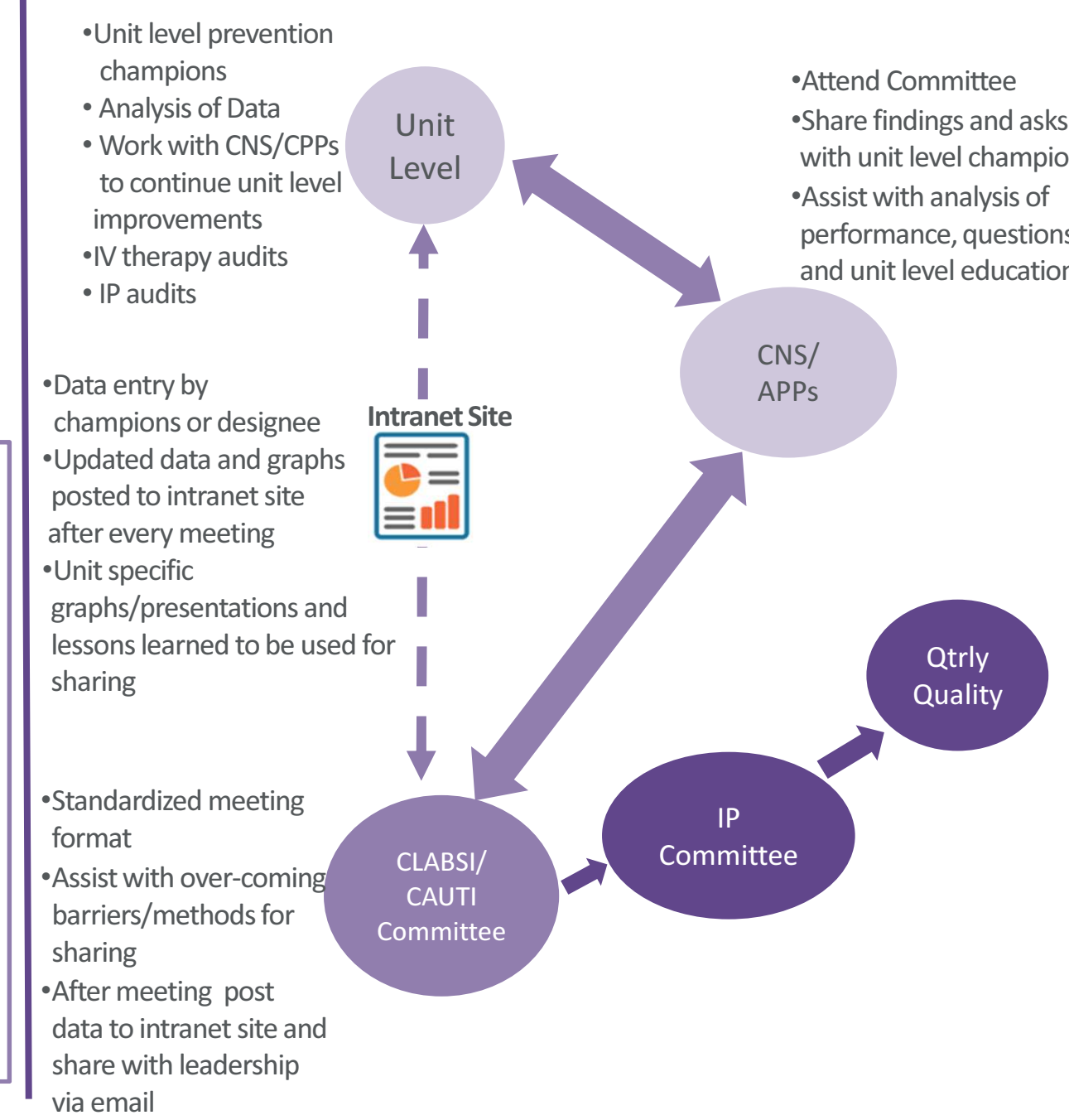
### Why Standardize & Develop Formal Flows of Info?



- IP Surveillance Data
- NDNQI Data
- No process measures for current performance (guess work based on unwanted outcomes)
- Individual Unit initiatives/informal & irregular sharing
- No standard mechanism (format) for monitoring performance and sharing on unit
- Duplication of work and efforts without all involved parties’ knowledge
- Un-coordinated efforts don’t produce results and often perpetuate problem

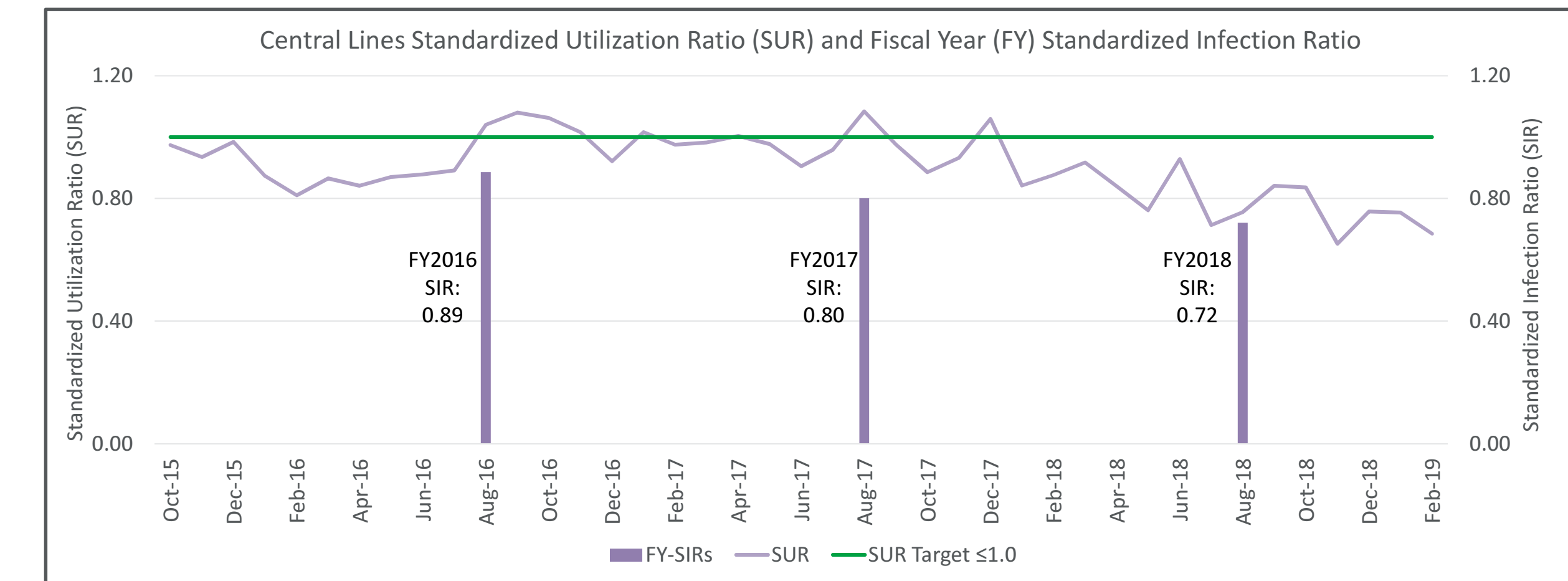
- Use IP (NHSN) data to drive performance
- Magnet, Public Reporting, Star Rating, Beacon
- Develop process measures that can be used to drive outcome measures
- Standardize CLABSI/CAUTI initiative tracking at unit level
- Uniform method for reporting and sharing starting at unit level
- Multipurpose use for reporting
- Earlier identification of barriers/opportunities
- Quick response to assistance
- Capturing unwanted outcomes before they occur

### What Does the Flow of Info Look Like?



## Results

All CLABSI related materials including performance graphs, dashboards and improvement tools are housed on a centralized intranet site that can be accessed on demand. Coordination of multi-discipline improvement efforts impacted CLABSI outcomes, specifically a decrease in CLABSI SIR and Central Line SUR.



## Discussion

A system-focused approach reduces variation in clinical practice and improves reliability.

Lessons learned include:

- Recruit a senior leader/executive sponsor. Active and visible sponsorship is critical to success.
- Set ambitious stretch goals to push through stagnant performance.
- Deliver clear, concise, consistent, and timely communication to the intranet site.
- Message follow-up is necessary in the beginning of the new communication strategy.
- Don’t make a commitment to maintain a centralized intranet site, unless it can be sustained; creating and maintaining a intranet site is time-intensive.