Nurses Role in CLABSI Prevention – Do no harm
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DISCLOSURES

Employee of Medline Industries, Inc.
Opinions expressed are my own and not necessarily representative of Medline Industries, Inc.
Objectives

• Discuss nursing theory and ethics
• Examine steps for initiating change
• Describe a successful change process
Jean Watson, PhD, RN, AHC-BC, FAAN

- Art-Humanities-Science
- Discipline versus Profession
- “Caring” is consistent with Nightingale’s sense of “calling”
- Evidence-Based Practice (EBP)
- Caring - Outcomes
Clinical Ethics

- Beneficence, Non-maleficence, Justice and Respect for Autonomy
  - Empathy, Compassion, Fidelity, and Integrity
- Clinical Judgement & Clinical Uncertainty
- Medical errors
- Moral distress
- Healthcare inequities
- Costs in clinical decisions
EBQI Versus Clinical Research

- Infusion Nurses Society Standards of Practice\(^3\)
- CDC Guidelines for the Prevention of Intravascular Catheter Related Infections\(^4\)
- Institute for Healthcare Improvement
Holistic Nursing & EBP

EBP culture & environment

Context of caring

- Research evidence & evidence-based theories
- Clinical expertise and evidence from assessment of the patient’s history and condition as well as healthcare resources
- Patient preferences and values

Clinical decision-making

Quality patient outcomes
ORGANIZATION CHANGE

- Change theories
- Change in Healthcare
- Sustainability
- Change agent qualities
Healthcare Acquired Infections

A Meta-Analysis

- Over 5 million CVCs inserted annually\(^6\)
- Up to 25% mortality rate\(^6\)
- Estimated cost of the 5 most common HAIs = $9.8 billion\(^5\)
  - CLABSI ranks 4th and accounts for 18.9% of total cost
    - Per case CLABSI was found to be the most costly = $45,814
      - MRSA CLABSI = $58,614 + higher LOS
  - 65-70% CLABSI are preventable with current EB interventions
What does this mean to hospitals?\textsuperscript{6,7}

- 3\% HRRP
- 2\% VBP
- 1\% HACs

Total: 6\%
Financial Implications

For every $100,000 that a hospital spent on safety programs, it realized an average $315,000 savings thanks to fewer infected patients.

- More than 60,000 primary bloodstream infections related to central Intravenous catheters are estimated to occur each year in the U.S., with a fatality rate of 12% or more.

A study published in JAMA Internal Medicine Journal evaluated data from the last 10 years CRBSIs at 113 hospitals showed:

- Safety interventions, on average, reduced infection rates by 57%.
- Produced a net savings of $1.85 million per site over three years.
- Savings came from reduced costs in treating infected patients.
IT IS TIME TO BUILD YOUR TEAM

You

PICC Team
Infection Prevention
Physician Champion
Nursing Education/Professional Practice
Chief Nursing Office
Purchasing
### Facilitators & Barriers

#### Facilitators

- Interdisciplinary approach
- Empowerment to STOP bad practice
- Partnership with senior medical & nursing staff on individual units
- Project leader is credible among peers and role models strict compliance with protocol/checklist and is sincere about the value of the program

#### Barriers

- Local leader driving change versus centrally lead programs
- Goals, interest and priorities of the program are misaligned with staff
- Unsupported hierarchical cultures – improvement opportunities often go unrecognized
- Poor executive leadership
- Hostile individuals – apathy, exasperation and bewilderment
Vision, Innovation, Transformation

Questions to Ask

- Does staff fully understand the IHI Bundle and are they compliant?
- Who reviews your policies?
- How often are policies reviewed?
- What evidence supports your policies, procedures and practice?
- Who does CVC/PICC insertion, education and competency?
- How often is vascular access education done?
  - Upon hire?
  - Annually?
  - Change in job description?
- How often is vascular access education done?
"Challenges are what make life interesting and overcoming them is what makes life meaningful."

- Joshua Marine -

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Find your story

- Compassion
- Empathy
- Fidelity
- Integrity
What Change Looks Like

In the beginning

- CMS ruling to stop paying for CLABSI
- Assembled a team
- Deep dive into practice, policy and products
- Shared Governance
- Education and Empowerment
Variability

- **Education**
  - Train People
  - Provide Instructions
  - Provide the Same Materials

- **Kits**
  - Develop Process Measure and Utilize to Control Variability
Guidelines for the Prevention of Intravascular Catheter Related Infections

- Education, Training & Staffing Recommendations
  - Educate healthcare personnel regarding the indications for intravascular catheter use, proper procedures for the insertion and maintenance of intravascular catheters, and appropriate infection control measures to prevent intravascular catheter-related infections [7–15]. Category IA
Bundles are intended to test a theory

Elements implemented together produce better outcomes

“Bundles” reduce variability and engineer standardized practice
CVC Maintenance Kits are clinically important in CLABSI reduction\textsuperscript{13}

Best practice interventions that promote “bundles” of procedures and technology combined with multimodal \textit{implementation} and dissemination \textsuperscript{12}

\textbf{Single use kits} are designed to follow the correct procedure sequence \textit{every time} with every clinician \textsuperscript{14}
Disseminate the Evidence\textsuperscript{15}

- Podium/Oral Presentations
- Present a poster
- Publish a paper
- Write a healthcare policy
- Nursing grand rounds
- Local Professional Chapters
- Hospital/Organizational Professional Committee Meetings
- Apply for a grant
We can’t pretend any more that what we do doesn’t affect people

- Courage
- Compassion
- Connection
- Shame
- Vulnerability
In closing

- Uncertainty
- Gratitude
- Celebrate
References


References


References


