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Major Article

Encouraging employees to speak up to prevent infections: Opportunities to leverage quality improvement and care management processes

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Background: Central line–associated bloodstream infections (CLABSIs) are associated with increased morbidity, mortality, and cost for U.S. hospitals, but many infections are preventable. Employees' willingness to speak up about errors or opportunities for improvement has been associated with a stronger safety culture in hospitals. However, the link between organizations' efforts to promote speaking up and prevent CLABSIs has not been studied.

Methods: This exploratory, qualitative study included interviews with 158 key informants, including hospital executives, managers, and staff employees, in 6 hospitals that participated in the federally funded On the CUSP—Stop BSI initiative. Verbatim transcripts were analyzed to examine whether and how speaking up was addressed in CLABSI prevention efforts.

Results: Hospitals implementing evidence-based practices for CLABSI prevention facilitated employees' improvement-oriented speaking up by leveraging quality improvement and care management processes. Leader behavior, employee training, and error reporting systems also facilitated speaking up. Although the focus of this study was on CLABSI prevention, broader organizational practices to improve patient safety were salient in creating a nonpunitive, highly inclusive environment in which employees felt comfortable speaking up.

Conclusions: These findings provide insight into the factors that may support speaking up to foster a safety culture and prevent health care–associated infection at unit and organization levels.

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Central line–associated bloodstream infections (CLABSIs) are among the most common health care–associated infections (HAIs), accounting for an estimated 85,000 preventable infections, 10,000 preventable deaths, and \$1.7 billion in avoidable medical costs each year.¹ As a result, CLABSI prevention has become a top patient safety priority in the United States, and recent efforts have seen infection rates decrease by nearly 60%.² Key to this success has been both

the development of clear clinical guidelines for CLABSI prevention in intensive care units (ICUs), such as standards for line insertion and maintenance, process standardization, and the use of checklists,³ and coordinated, state, local, and regional efforts to disseminate and support adoption of these evidence-based standards.^{2–4} Beyond clinical standards, CLABSI prevention efforts have also included a focus on improving safety culture within ICUs, but the link between these organizational culture change efforts and CLABSI outcomes has not been specifically evaluated.^{3,5}

The concept of a health care safety culture has emerged from findings in other high-risk industries, such as aviation, in which a preoccupation with failure and focus on improving systems, rather than blaming individuals, have led to high degrees of safety.⁶ Strong health care safety cultures have been positively associated with higher quality outcomes in health care organizations⁷ and are characterized by focus on improving systems and supporting open dialogue to facilitate safer practices.^{8–10}

One defining characteristic of a strong health care safety culture is that individuals are willing to speak up about errors or opportunities

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for improvement without fear of blame or repercussion¹¹; this represents a shift from the traditional culture of health care organizations in which employee reluctance to speak up has been widely recognized as a barrier to quality.¹² Research on speaking up has found that this behavior is complex and influenced by a motivational asymmetry, in which the perceived personal risks of speaking up outweigh the potential benefits that are often unknown or unclear¹³ or employees fear repercussions to themselves and others.^{14,15} Although there is evidence that leader behaviors, such as being inclusive and seeking feedback, can contribute to employees' perceptions that the environment is safe for speaking up,¹⁶ research has not yet identified specific management and organizational practices that can facilitate speaking up.

We aimed to explore whether and how speaking up was addressed as part of a qualitative study of U.S. hospitals that participated in a state-level CLABSI prevention initiative designed to disseminate and support adoption of evidence-based clinical guidelines for CLABSI prevention and unit-based safety culture improvement. We conducted an in-depth analysis of key informant interviews conducted at 6 of the participating hospitals, taking advantage of a unique opportunity to explore the broader phenomenon of speaking up in this context. Our study contributes to the literature on HAI and CLABSI prevention by providing insight into ways in which management can facilitate and remove barriers to speaking up to support these efforts.

METHODS

Study design

Using a multiple case study design,¹⁷ we conducted an exploratory, qualitative study of U.S. hospitals' CLABSI prevention efforts. Data were collected during site visits to 6 hospitals that were purposively selected for this study. Iterative data analysis was conducted using inductive and deductive methods to examine how these hospitals' CLABSI prevention efforts encouraged or hindered employees' efforts to speak up to prevent errors or identify opportunities for improvement.

Study sites

The study sample was comprised of 6 hospitals from 3 states selected on the basis of their participation in a national CLABSI

prevention initiative. Using a design of contrasting cases, the sample included 3 pairs of hospitals matched on organizational characteristics, including organizational structure, size, and state. Included in each pair was 1 hospital that had good outcomes and 1 that had less good outcomes relative to others in their state based on CLABSI rates reported at the start and 18 months after the organization's participation in the national initiative. We used an iterative process to select pairs within each state. First, organizationally similar hospitals were grouped and then stratified based on CLABSI outcomes to identify potential pairs within each state. Next, we asked state-level coordinators for the national initiative for input regarding the potential pairs' outcomes, comparability, and likelihood to participate in the study. We then corresponded with contacts at the select hospitals to confirm participation in the study and coordinate 2-day research site visits. This methodology enabled a robust analysis of factors that might influence infection control, while at the same time controlling for potential variation caused by organizational characteristics.¹⁷ The final sample included 2 freestanding community hospitals located in large metropolitan areas, 2 large tertiary and teaching hospitals located in large cities, and 2 system-affiliated community hospitals located in small urban areas.

Data collection

The primary data source for this study was interviews with a wide range of key informants from each of the study sites, including organizational leaders, professional staff, clinicians, and frontline employees. To ensure consistency across sites, the research team developed a generic list of potential key informants based on job title and organizational role. This list was shared with a site-based liaison who identified appropriate informants and provided recommendations about other key informants. With participants' informed consent, we secured informants' voluntary participation and their permission to record interviews for later transcription. We received Institutional Review Board approval from The Ohio State University to conduct this study.

We conducted a total of 158 key informant interviews with organizational leaders, professional staff, clinicians, and frontline employees. Table 1 presents summary descriptions of the study sites, along with detail about the numbers and types of key informants at each site.

Table 1
CLABSI prevention case study sites

Pair no.	Pair characteristics	CLABSI outcome	Site	Site characteristics	Key informants
1	Freestanding community hospitals located in large metropolitan areas	Good	Site 1	<ul style="list-style-type: none"> • 496 beds • 22 ICU beds 	<ul style="list-style-type: none"> • Executive (n = 6) • Management (n = 8) • Staff (n = 14)
		Less good	Site 2	<ul style="list-style-type: none"> • 441 beds • 43 ICU beds 	<ul style="list-style-type: none"> • Executive (n = 4) • Management (n = 12) • Staff (n = 14)
2	Tertiary care and teaching hospital located in midsize cities	Good	Site 3	<ul style="list-style-type: none"> • 1,192 beds • 259 ICU beds (9 units) 	<ul style="list-style-type: none"> • Executive (n = 7) • Management (n = 7) • Staff (n = 11)
		Good*	Site 4	<ul style="list-style-type: none"> • 815 beds • 147 ICU beds (4 units) 	<ul style="list-style-type: none"> • Executive (n = 5) • Management (n = 16) • Staff (n = 17)
3	System-affiliated community hospitals located in small urban areas	Less good	Site 5	<ul style="list-style-type: none"> • 373 beds • 53 ICU beds (2 units) 	<ul style="list-style-type: none"> • Executive (n = 4) • Management (n = 5) • Staff (n = 12)
		Good	Site 6	<ul style="list-style-type: none"> • 376 beds • 52 ICU beds 	<ul style="list-style-type: none"> • Executive (n = 2) • Management (n = 4) • Staff (n = 10)

CLABSI, central line-associated bloodstream infection; ICU, intensive care unit.

*Site 4 was initially selected as less good based on the On the CUSP—Stop BSI initiative project data and input from the project liaison. However, because this hospital had made a successful turnaround since the conclusion of the project, it is more appropriately categorized as good for the purposes of this analysis.

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