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Contents lists available at ScienceDirect

## American Journal of Infection Control

journal homepage: [www.ajicjournal.org](http://www.ajicjournal.org)

## Major Article

## Leadership rounds to reduce health care–associated infections

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## Key Words:

Leadership  
leadership rounds  
walk rounds  
health care–associated infections  
psychologic safety  
learning climate

**Background:** Evidence-based guidelines exist to reduce health care–associated infections (HAIs). Leadership rounds are one tool leaders can use to ensure compliance with guidelines, but have not been studied specifically for the reduction of HAIs. This study examines HAI leadership rounds at one facility.

**Methods:** We explored unit-based HAI leadership rounds led by 2 hospital leaders at a large academic hospital. Leadership rounds were observed on 19 units, recorded, and coded to identify themes. Themes were linked to the Consolidated Framework for Implementation Research and used to guide interviews with frontline staff members.

**Results:** Staff members disclosed unit-specific problems and readily engaged in problem-solving with top hospital leaders. These themes appeared over 350 times within 22 rounds. Findings revealed that leaders used words that demonstrated fallibility and modeled curiosity, 2 factors associated with learning climate and psychologic safety. These 2 themes appeared 115 and 142 times, respectively. The flexible nature of the rounds appeared to be conducive for reflection and evaluation, which was coded 161 times.

**Conclusions:** Each interaction between leaders and frontline staff can foster psychologic safety, which can lead to open problem-solving to reduce barriers to implementation. Discovering specific communication and structural factors that contribute to psychologic safety may be powerful in reducing HAIs.

Published by Elsevier Inc. on behalf of Association for Professionals in Infection Control and Epidemiology, Inc.

It is estimated that 1 in every 25 patients in the United States is diagnosed with a health care–associated infection (HAI).<sup>1</sup> Given the magnitude of this problem, state and federal agencies such as the Veterans Health Administration, Centers for Medicare and Medicaid Services, and the Agency for Healthcare Research and Quality are working diligently to promote adherence with evidence-based practice guidelines for reducing HAIs.<sup>2–5</sup>

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Funding/support: Supported by an Association for Professionals in Infection Control and Epidemiology (APIC) Graduate Student Award; the APIC; the APIC Research Fund; and the VHA National Center for Patient Safety Center of Inquiry, U.S. Department of Veterans Affairs.

Disclaimer: The views expressed in this article are those of the authors and do not represent the views of the U.S. Department of Veterans Affairs or the U.S. Government.

Conflicts of interest: None to report.

Many evidence-based and best practice guidelines and toolkits now exist. However, despite national efforts to disseminate and implement practice guidelines, the reduction of HAIs remains a formidable task. Those involved in decreasing HAIs are now emphasizing the how, or the process of moving evidence to practice in real work settings (ie, implementation science). Because of the complexity of the health care setting, implementation experts recommend thoughtful consideration of context.<sup>6</sup> Context includes health care leaders who play a critical role in implementation.<sup>7–10</sup> Infectious disease experts have recognized the need to further explore leadership as part of implementing guidelines at the front-line of health care.<sup>11</sup>

Leadership rounds (LRs) are a tool that can be used to connect leaders with frontline staff. LRs have been used as a quality improvement tool and are typically described as senior or executive leaders meeting with frontline staff in a location where the work is done, such as the hospital unit hallway. This type of rounding was conceptualized in 1999 by the Institute for Healthcare Improvement. The Institute for Healthcare Improvement found that Executive

Walk Rounds were a way to connect senior leadership with front-line patient safety issues and advance a culture of safety.<sup>12</sup> Whether leaders are hospital executives or midlevel manufacturing managers, the concept of managing by walking around became popular in the 1980s when *In Search of Excellence*<sup>13</sup> highlighted Hewlett-Packard's management style of getting out of the office and getting to know people while casually inquiring about work or project status. Gemba Walks is derived from a Japanese term meaning real place. Gemba Walks, created by Taiichi Ohno, a Toyota executive,<sup>14</sup> stresses in-person interaction with the goal of leaders of understanding the value stream (analyzing the current state and designing a future state), tapping into the expertise of frontline employees (the end user) to solve problems.

In response to government mandates, and in answer to the patient safety issue of rising rates of catheter-associated urinary tract infections (CAUTIs), LRs were initiated at the University of Wisconsin (UW) Hospitals and Clinics, Madison, Wisconsin. Two executive leaders—the senior vice president of medical affairs (associate chief medical officer) and the vice president of nursing (associate chief nursing officer)—had a goal of visiting units regularly to determine whether evidence-based and best practices were being routinely integrated into daily unit operations. Because of a significant and rapid reduction in CAUTI rates after initiation of LRs (Fig 1), executive leaders continued the initiative and, over a span of 6 months, LRs were expanded to include 2 additional infections—central line-associated bloodstream infection (CLABSI) and *Clostridium difficile* infection (CDI).<sup>15</sup> This expanded version became known as HAI LRs.<sup>16</sup>

There have been studies related to leadership and the reduction of HAIs, but there have not been studies specific to the use of LRs for reducing HAIs.<sup>17-20</sup> This study provides an in-depth look at one hospital's use of LRs to reduce HAIs and identifies key structural characteristics along with key leader communication behaviors used during these LRs.

## METHODS

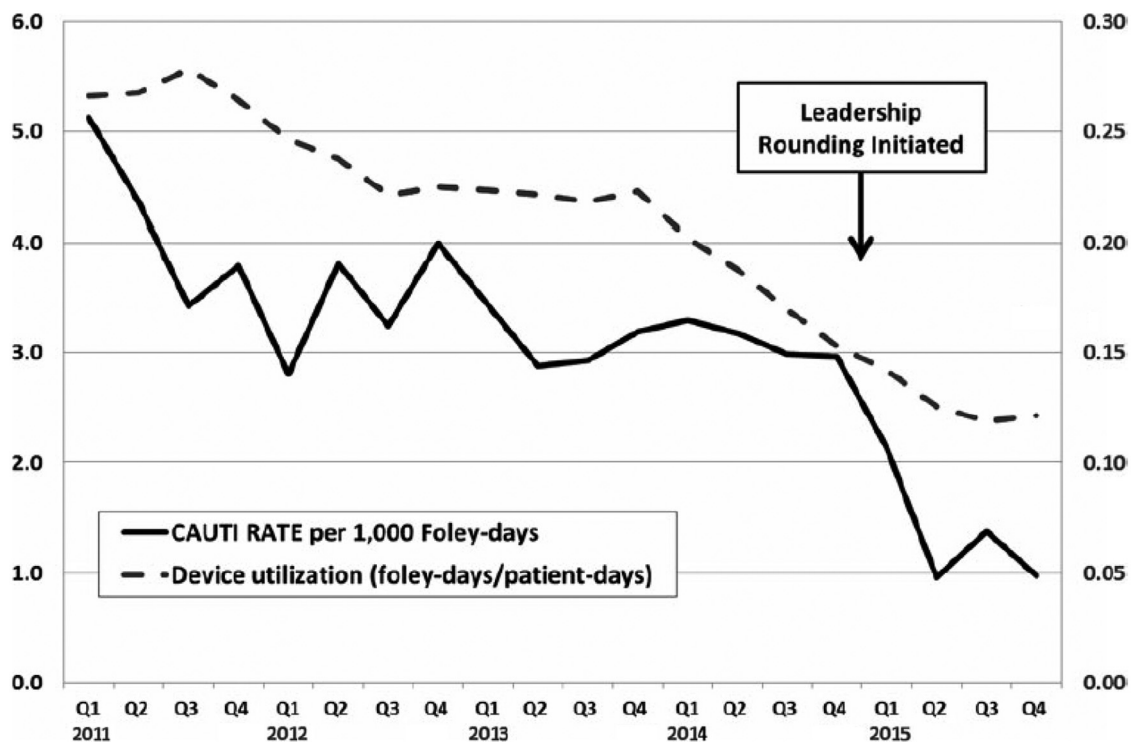
### Study setting and design

A case study design was used to assess HAI LRs conducted at 2 hospitals within UW Health, University Hospital, and the American Family Children's Hospital, in Madison, Wisconsin. This study was considered quality improvement and exempt from institutional review board approval. The case is defined as all UW hospital units experiencing HAI LRs with a focus on 5 hospital units for further data collection. The study population included hospital executive leaders, infection preventionists (IPs), and frontline staff from 5 units, providing variation in patient population (acuity, age, and type of service), staffing, unit size, and infection rates.

### Data collection

Unit-level observations of LRs and key informant interviews were used sequentially, with themes emerging from observations, providing questions for key informant interviews. Observational data included 8 pilot nonrecorded observations (written notes only) and 22 recorded observations (total of 15 hours of observation and 11 hours of recorded conversations). The 22 recorded observations (from 19 different units) were completed over a period of 7 months. The observer did not participate in conversation with staff or leaders during these observations.

Semi-structured key informant interviews were conducted with the 2 executive leaders conducting the LRs, a physician provider, 3 graduate-level IPs, 6 staff nurses and care team leaders (frontline), and 8 nurse managers and clinical nurse specialists. Interview questions were piloted with 1 IP and 1 clinical nurse specialist with modifications made based on pilot suggestions. The prerequisite for being interviewed was attending at least 1 unit-level HAI LR. All interviews were conducted by the first author and were limited in



**Fig 1.** CAUTI (solid line, scale on left axis) and indwelling urinary device utilization (dashed line, scale on right axis), calculated quarterly, 2011-2015. Reprinted with permission from Wolters Kluwer Health. CAUTI, catheter-associated urinary tract infection rate; Q, quarter.

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