DENISE MURPHY

Changing attitudes: Creating a culture of accountability in infection control

INTRODUCTION: Denise Murphy, MPH, BSN, RN, CIC, vice president for safety and quality at Barnes-Jewish Hospital at Washington University Medical Center in St. Louis, and immediate past president of the Association of Professionals in Infection Control and Epidemiology (APIC), has spent her career working to prevent healthcare-associated infections (HAIs) in hospitals ranging from 200 to 1,200 beds. As a member of the Centers for Disease Control and Prevention's Hospital Infection Control Practice Advisory Council, she helps shape national policy aimed at reducing HAIs.

This summer, APIC announced its "Targeting Zero" initiative aimed at reshaping hospital culture to recognize that even one HAI is one too many. In this podcast, Murphy speaks about how a focus on personal accountability created such a culture shift at Barnes-Jewish Hospital and how it has impacted HAI rates.

INTERVIEWER: In its position statement on the "Targeting Zero" initiative, APIC says it will focus on creating a culture where targeting zero is fully embraced. How do we define "fully embraced," and by whom are we hoping or expecting to embrace the concept of targeting zero?

D. MURPHY: I think that who we really need to embrace this are the people that deliver patient care at the bedside. I always refer to that as the front line, and I'll apologize in advance if I overuse that, but I think all the time of, you know, the front line is where patient care happens. So if a bunch of infection preventionists are really living and breathing this and being passionate about it, that's great. If we can sell this to our leadership, which we must do for it to go anywhere, that's critical. But to really prevent infections, this has to be embraced by the doctors, the nurses, pharmacists and respiratory therapists, physical therapists and laboratorians—all the people that come together to make up the multi-disciplinary teams that provide patient care. That's who we need to get to fully embrace this. And so we're asking really busy people whose primary focus is just delivering patient care in the moment to step back, mentally step back, before they do things with patients and remember the infection prevention measures that are going to protect these folks.

So this is not an easy concept to get people to embrace, but I think the more personal we make it—when we personalize infections and we stop talking about them as numbers or rates or incidents—I think it really helps us all remember why we went into healthcare and who we are really there to protect.

INTERVIEWER: The "Targeting Zero" position statement stresses that zero tolerance doesn't necessarily mean that noncompliance will be met with punishment, but will encourage accountability and education. Do you think that this creates a bigger sense of buy-in from those who do choose to adopt the targeting zero culture?

D. MURPHY: I sure do. And I'll tell you, I can give you a real-life example, it happened right here at Barnes-Jewish Hospital. Our cardiothoracic intensive care unit went 15 months without a bloodstream infection in that ICU, and so they were our hospital champions and the model that we held for everyone else and said, "If they can do it, we can all do it, and they're going to help us design the perfect patient care experience so that no one ends up with a complication." And they were just as proud as peacocks.

So they end up—the lab calls the infection preventionist, and before she can even call the floor, the nurse manager is on the phone. She's in crisis because they have a bloodstream infection. The infection preventionist says, "I know. I'm on my way up." And they do a mini root-cause analysis, or what we call a rapid response to BSI. They go right up there. They try to pull the people together, if possible, not just the nurse involved in the patient care, but the person that inserted the line.

We have good documentation today. We didn't always have, but we have good documentation on who inserted the line. We pull everyone together that we can and we go through our list of questions. Why did this happen? Why did that happen? What do you think about this? Was it easy to comply with all the prevention measures? If not, where do you think that maybe we weren't so tight on our process? Exactly what step of the process do you think we might have missed?

So we've got one of the ICU nurses, she's a rather new nurse. She is in this root-cause analysis and she said, "Do you know what? I have to admit that I've done things outside of our policy. In a hurry and based on pressure from a doctor needing blood, I went into the central line to draw routine blood work. I know that you're not supposed to use a central line for that, but I did that and I had

no excuse other than I was bending to the pressures of the doctor wanting this right away and I went outside of policy. I feel terrible." And we said, "You know, that's okay. I mean, we understand that these pressures occur. What can we do to make it easier for this to be the standard of practice in this ICU so that no doctor will ever ask you to draw blood out of a central line?"

You know, in a just culture, you've got an employee that will stand up and say that who is not afraid to be fired. So what we did was we met with the ICU medical director, and he met with the doctor that was pressuring. What we found out actually, because she spoke up, we found out he was doing this with a lot of the nurses. He was from another country, and his culture was such that they didn't ever want to stick the patient extra times, so he was doing this for a good reason. He didn't want to create pain for the patient. So to answer your question, absolutely, yes. Creating the culture in which people feel like they'll be held accountable but they won't be punished for human error, and they really won't be punished for shortcuts that our system is creating for them or forcing them to do, then I think we've got everybody willing to say we can get to zero. Yes, we can do this, and we're not afraid to admit when we make mistakes.

INTERVIEWER: What impact did that culture change have on infection rates at Barnes-Jewish?

D. MURPHY: Oh, my goodness. It's been mind-boggling. We've been on this very seriously since 1999 or 2000, and so we were able to drop rates by 50 and 60 percent in all of the ICUs, and I'm talking about bloodstream infections and ventilator-associated pneumonia and surgical-site infections, so we felt like we were sitting on the top of the world.

We started looking at our infection rates and that they were just dropping lower and lower and lower every year. Well then, we said, you know what though? When we count these up, it is exciting that we went from—in a giant place like this with thousands and thousands and thousands of central lines. When we started this work, we had about 300 a year, and then we got to about 150, and then we got down to 75, and then a year and a half ago we were at 66, and then this year we're at about 40-some. We're saying to ourselves, "This is terrible. How can 40 patients in our hospital have a life-threatening infection?"

So when you watch the culture change, from accepting that, well, yeah, we're a big academic medical center, 300 bloodstream infections, really that's probably nothing considering all the lines we insert. Today they are saying, "We've got 40 bloodstream infections, that's horrible. We don't want any."