Sustaining and Spreading Improvement in Hand Hygiene Compliance

Features

Infection Prevention and Control

- Editorial: Toward More Reliable Processes in Health Care
- Improving Hand Hygiene at Eight Hospitals in the United States by Targeting Specific Causes of Noncompliance
- Beyond the Collaborative: Spreading Effective Improvement in Hand Hygiene Compliance

Performance Improvement

- Using Lean Management to Reduce Blood Culture Contamination

Teamwork and Communication

- Implementation of a Standardized Postanesthesia Care Handoff Increases Information Transfer Without Increasing Handoff Duration

Department

Field Notes

- Inviting Families to Participate in Care: A Family Involvement Menu

“If other quality and safety problems exhibit the same characteristics as hand hygiene noncompliance, attempting to address them everywhere with exactly the same set of interventions is likely to fail because the key causes of the problem will differ from place to place.”

— Beyond the Collaborative: Spreading Effective Improvement in Hand Hygiene Compliance (p. 24)
Inviting Families to Participate in Care: A Family Involvement Menu

Field Notes provides a forum for brief reports (approximately 2,000 words) on in-progress innovations in quality and patient safety. Readers are invited to send Field Notes proposals to Steven Berman at sberman@jcrinc.com.

Rhonda M. Wyskiel, RN, BSN; Kristina Weeks, MHS, DrPH(c); Jill A. Marsteller, PhD, MPP

Driving Forces
The ICU is a fast-paced care setting, with critically ill patients connected to multiple tubes and machines. Clinicians move quickly from patient bedside to beeping machine to co-workers to another patient, and they have little time to interact with patients and families. As a result, all too often, patients, friends, and family members feel secluded and uninformed, which creates a sense of uncertainty, vulnerability, and anxiety.1 The composite vignette in Sidebar 1 (right) illustrates how family involvement can help improve care. Patient/family-centered care offers one approach to help clinicians interact with and include patients and families in medical care. The Institute for Patient- and Family-Centered Care describes four core areas of this approach—respect and dignity, information sharing, participation, and collaboration.2 In addition, the American College of Critical Care Medicine recommends that families assist in caring for their loved ones.3 At The Johns Hopkins Hospital (Baltimore), patient/family-centered care interventions initially targeted the pediatric population until about 2009. Efforts then spread to adult areas, with a focus on the critical care environment, where effective communication and engagement of families is particularly important in decision making.

Staff in the Weinberg Intensive Care Unit (WICU) have demonstrated a commitment to patient/family-centered care since 2000. In 2013 The Johns Hopkins Hospital made research, teaching, and provision of patient/family-centered care a strategic priority. To position patients and families at the center of care, the WICU initiated open visitation and family presence during emergent situations and during daily rounds with the health care team. The unit has developed a patient-centric culture, enabling implementation of additional patient-family interventions. Yet for patient/family-centered care to truly be a part of the WICU culture, we believed that family members and surrogate decision makers should be invited to join the multiprofessional care team. In February 2010 a WICU nurse used informal surveys and conversations to

Duration of Initiative: 4 years
Setting: The Weinberg Intensive Care Unit (WICU) is a 20-bed surgical oncology ICU that admits approximately 4,300 patients annually and has a nurse-to-patient ratio of 1:1 or 1:2. The WICU is part of the Johns Hopkins Hospital, a 1,059 licensed-bed urban academic medical center with 120,000 annual admissions.

Whom This Should Concern: ICU nurses, patients, family members, caregivers, patient safety and quality improvement professionals, physicians, managers and hospital management.

Sidebar 1. Composite Vignette Illustrating Family Involvement

This composite vignette illustrates how family involvement can help improve patient care.

After elective gall bladder surgery, Mrs. S. developed postoperative complications unexpectedly extending her hospital stay. Every day, staff watched as her husband stood over his wife’s bed, looking sad, scared, and helpless, whispering “I wish I could help you get better, my love.” When Mr. S. visited, he rarely touched his wife. One day, a nurse offered to put the side rail down so Mr. S. could sit and hold his wife’s hand; he really perked up. “I wasn’t sure if touching her would hurt her or mess up one of the lines that are connected to her.” The nurse explained that his touch might actually help his wife and that he knew her better than the health care team. She asked him about some bruises on his wife’s legs that the team thought might have occurred during surgery. Mr. S. explained that his wife was an avid gardener and the bruises had, in fact, happened at home a few days before her surgery. “She was on her knees for hours tending the vegetables in her garden,” he explained. The next day, Mr. S. held his wife’s hand. The nurse invited him to tuck pillows when she turned his wife and to help with applying barrier cream to the bruises on her lower legs. On the following day, Mr. S. came in and noticed that the same nurse was working. He asked if he could help with the same things he did the day before: “It made me feel like I was helping her. It’s nice to not just sit and read the newspaper.”
determine what care activities clinicians felt that families could perform and what activities family members felt they would like to provide for their loved ones. Findings from those interviews informed the creation of the Family Involvement Menu (FIM) tool, which reflects the activities that clinicians and family members believed that they could partner together and provide for the patient. The nurses knew that it was imperative to involve staff and family members in this process if they expected the tool to be used.

Research suggests that scarce resources for health care professionals and unengaged families can lead to patient harm, a longer hospital stay, greater resource use, and caregiver dissatisfaction and turnover. Patient participation is strongly linked to patient safety, and in the ICU, family members are the surrogate participant for critically ill patients. Evidence supports the benefits of engaging patients and families in care, including enhanced psychological safety and possible improvement in a family member’s ability to cope with the patient’s situation. Patients feel safer with a family member present and believe that it is their right to have family present and involved in direct care. Patients and families want to be involved in health care decision making, want providers to respond to their needs, and associate high-quality ICU care with open communication and involvement. Many family members have provided care for these chronically and terminally ill patients in the home. Including families as members of the care team enables providers to take advantage of their knowledge of the patient’s medical history, preferences, and well-being. We expected that families’ involvement in direct care would provide additional time and monitoring resources for hospital staff. The FIM represents a commitment to patient/family-centered care and a way of thinking that prizes communication, collaboration, and medical insights gained through the experiences of patients and their friends and relatives.

**Initiative Description**

The FIM, first developed in August 2010 after a six-month effort led by a senior clinical nurse with training in patient safety, consisted of a one-page laminated document that hung in each patient room. The FIM invited family members and caregivers to participate in the care of the patient by performing any activity listed on the FIM (Figure 1, right). This simple, low-technology, low-cost intervention requires minimal training for providers, including an engagement exercise with the staff, orientation to the tool itself (education), discussion of strategies to engage families in direct care, putting the tool into use (execution), and then ongoing evaluation of how it is going, with subsequent adjustments or additional education and reengagement. On admission to the ICU and throughout the patient’s stay, nurses invite family members or caregivers to select activities from the FIM, from brushing teeth to assisting with ambulation (Figure 1). Training families on care participation does vary. Some activities, such as hand care or distraction, require little training, while range of motion or ambulation assistance are more complex tasks that require the clinician to provide more thorough instruction and assistance to family members during their participation. All family members are invited to participate in these activities; they decide when, whether, and how to become involved.

**Family Involvement Menu**

We believe that you know the person that we are caring for far better than we do.

We would like to invite you to participate in your loved one’s care.

Listed below are options that you may choose.

If there is a particular care that you would like to assist with and it is not listed, please speak with your nurse.

We will provide instruction as needed for each of the following according to your comfort level.

- Oral care
- Incentive spirometer
- Range of motion
- Back care
- Leg care
- Assist with ambulation
- Assist with feeding
- Hand care
- Shampoo
- Shaving
- Pillow repositioning
- Distraction—Music, TV, reading
- Repositioning of foot drop splint

Thank you for your help. We are in this together!

**Figure 1.** On admission to the ICU and throughout the patient’s stay, nurses invite family members or caregivers to select activities from the menu, from brushing teeth to assisting with ambulation.
Some preliminary work should be done to ensure that staff and family members are ready to implement a FIM because it requires a change in practice and potentially a shift in hospital culture to include nonclinicians in the provision of care. Staff should be educated about the benefits, such as alleviating tasks from their workload and involving families to optimize patient care, and staff and family members should be included in the tool development process to ensure that “both sides” are comfortable with the care practices included in the tool.

**Barriers**

Engaging clinicians and family members in patient/family-centered care has posed some challenges. Traditional boundaries between the work of clinicians and the passive role of families during a hospital stay have been difficult to hurdle. Among clinicians, there were early adopters, late adopters, and some “never users.” Clinicians who have not adopted the FIM note they are too busy to teach family members how to do some of the tasks. In addition, some family members have been reluctant to perform some of the tasks because they fear doing something wrong, such as accidentally disconnecting a wire or device. These families typically had never visited an ICU and were provided reassurance, education in some cases, and reintroduction of the FIM at another point during the patient’s stay.

Spreading the FIM to other clinical units and institutions has also been a challenge. The FIM requires more than simply asking the family to choose and perform a task. A unit must have an existing culture of patient/family-centered care, strategies to engage family members, and a commitment to use the FIM to deliver high-quality patient-centered care. Moreover, clinicians and family members must be ready to partner in the direct care of the patient. Bernabeo and Holmboe describe these factors as specific competencies that the system, providers, and patients need to properly conduct patient-centered care. In November 2013, when an oncology unit at The Johns Hopkins Hospital asked to use the FIM, a meeting was organized with leadership from that unit to better understand the unit’s culture and commitment to patient/family-centered care. Participants discussed the unit’s current projects and initiatives focused on patient-centered care and the level of commitment to the provision of such care. Themes that emerged during the discussion were summarized and used to design and plan the introduction of the FIM so that it would best meet the unit’s needs as expressed during the meeting. In September 2013 a conference presentation attracted the interest of rehabilitation specialists and occupational therapists at North Shore Long Island Jewish Hospital (Manhasset, New York), a 583-bed, nonprofit, tertiary care teaching hospital. Four coaching calls were conducted to discuss interest in the FIM, the current state of patient/family-centered care in their neurosurgical rehabilitation unit, and commitment from leadership to support the rollout of the FIM before North Shore’s team demonstrated these competencies. They are planning to build a FIM software application to allow families to use the tool on a tablet or other technology and plan to pilot test implementation in the near future. Other parties who have expressed interest in the FIM do not always understand the need to first investigate the existing culture, assess readiness for this approach, and adapt the tool for the area of implementation on the basis of staff, patient, and family input.

**Key Learnings**

Our experience in the WICU leads us to the following conclusions:

- The FIM resonates with providers and caregivers and is a tangible example of a patient/family-centered intervention.
- The FIM helps meet patient and family member needs. Family members have expressed enhanced ability to cope with their loved one’s condition and improved communication and information sharing between clinicians and families.
- Some nurses noted that the FIM care activities frees up their time to focus on more complex clinical tasks.
- It is important to adapt the FIM of tasks to meet the needs of the patient population.
- We found better buy-in when we involved clinicians, patients, and families in developing a unit-specific FIM.
- It is critical to understand the existing culture in the unit/area and assess staff members’ readiness to use the FIM and to establish a strong culture of patient/family-centered care.
- Caution! FIM implementation will fail if there is inconsistent support from unit/area leadership, and if clinicians are not engaged or ready to use it. Unit champions can mitigate resistance among some clinicians who see the FIM as burdensome.

**What’s Next**

We are currently developing a training and implementation toolkit for the FIM. In addition, with support from the Betty and Gordon Moore Foundation, we are conducting a pre-post evaluation among patients, families, and clinicians in two units newly implementing the FIM. WICU leadership continues to reinforce the vision of patient/family-centered care in the belief that care extends beyond administration of a medication or therapy to include showing empathy for those who spend countless hours visiting the person they may love the most in the world, who is lying helpless in a bed, hoping that their fami-
ily will comfort them through compassionate touch and caring. We have the moral obligation as health care providers to foster that connection. Family involvement is no longer just a “nice thing to do” but is necessary to ensure optimal patient experience.

Contact Us
For more information, please contact Rhonda M. Wyskiel, RN, rmalone1@jhmi.edu. We are particularly interested in others’ experience in engaging family members in direct care as part of a patient/family-centered care strategy.

The authors thank Christine G. Holzmueller, BLA, for her thoughtful review and guidance in organizing and editing the manuscript. The authors also thank Jo Anna Smith for permitting them to cite North Shore Long Island Jewish Hospital’s interest in the Family Involvement Menu.

Rhonda M. Wyskiel, RN, BSN, formerly Senior Innovation Lead, is Patient Safety Innovation Coordinator, Johns Hopkins Medicine, Armstrong Institute for Patient Safety and Quality, and The Johns Hopkins Hospital, Baltimore. Kristina Weeks, MHS, DrPH(c), is Faculty Research Associate, Johns Hopkins Medicine, Armstrong Institute for Patient Safety and Quality, and The Johns Hopkins University, School of Medicine, Baltimore. Jill A. Marsteller, PhD, MPP, is Associate Professor, Johns Hopkins Bloomberg School of Public Health, and Johns Hopkins Medicine, Armstrong Institute for Patient Safety and Quality, Baltimore.

References