

THE DEFINITION OF INSANITY

by John Salyer RRT-NPS, MBA, FAARC



Insanity: doing the same thing over and over again and expecting different results. -Albert Einstein. I love quoting Einstein. It makes me feel urbane and sophisticated (which I am neither). But whatever you may have thought of AI (and I have my issues with the good physicist), he could turn a phrase. My favorite Einstein quote goes like this, "Reality is merely an illusion, albeit a very persistent one." It is persistent as hell if you ask me.

Speaking of insanity and illusions, I have some neonatal ones for you to ponder; hand hygiene and nosocomial infections. A dirty little secret (well, not so little when you think about it) is the fact that nosocomial infection rates for hospitalized patients have not changed much in the last 30 years. There certainly some localized pockets of improvement, but even in the best run hospitals, there are periodic spikes in nosocomial infection rates that are troubling and often inexplicable.

This, in spite of significant on-going efforts on the part of hospitals to educate staff on the role of handwashing and other infection control practices in limiting the spread of nosocomial infections. Most hospitals have some program to monitor compliance with hand hygiene and infection control practices, but these are uneven and usually involved very limited periodic non-random observations and a very very small number of episodes of care.

The truth is that in spite of the obvious fact that the horse in on the ground, and in asystole, we continue to have only approx-

imately 60-80 % compliance with hand washing guidelines-policies-dictates among hospital workers. The data that I have seen indicate that nurses and RT's run neck and neck, and lead the pack in the race towards hand hygiene mediocrity, and medical staff are on the outside, bringing up the rear. You hardly ever see any data on imaging technicians, pharmacists, nutritionists, phlebotomists, families and others who frequent patient rooms. My suspicion is that the data on compliance with other isolations and infection control guidelines is even worse. Overall, compliance with hand hygiene is better, but still not consistently in the 90-95% range.

Some may feel that 80% compliance is a great improvement compared to where we used to be, and they are right, but it ain't good enough. Why is it that we are unable to master the fundamentals of something as important and rudimentary as hand hygiene and other infection control practices? I do not believe it is because we don't know what we are supposed to do. Instead I think it is because collectively we; are flawed, are forgetful, are sometimes very busy, are sometimes very tired, are ruled by the tyranny of the urgent, and have difficulty changing behaviors based on the abstract possibility of something that might happen in the future. Consider weight control and smoking in support of my premise.

While I am sure that our education and training systems related to infection control could be improved, I simply do not believe this is fundamentally an educational issue. I think this is an enforcement issue. I believe that most health care workers come to work every day desiring to do what is best for their patients. But sometimes the cacophony of what is around the staff makes it difficult to stay focused on something as abstract and lacking apparent immediacy as infection control practices and hand-hygiene.

When nosocomial infections do occur, they sometimes result in a lot of respective finger pointing between clinical disciplines. While this can be fun and entertaining it rarely bears long term fruit. Typically there are meetings and campaigns and slogans and classes, and sometimes things improve, but often these improvements are very hard to sustain.

One potentially more lasting solution would be for leadership of units and hospitals ought to help realign the concentration of the clinical staff on the urgency of hand hygiene and infection control practices through the good offices of corrective disciplinary action. And yet we seem to have a collective reluctance to knock heads together about this. This is understandable since no one enjoys saying challenging things to colleagues within and without your clinical discipline.

So, I have a hair brained scheme idea I am pondering; video recordings of patient rooms in the intensive care units (to start). Under the aegis of quality improvement I propose we carefully study compliance with hand hygiene and other infection control guidelines in the NICU environment (to start with) through the use of video cameras. Consider a feasibility study as follows:

1. Installing video cameras in selected rooms the NICU.
2. The cameras would be placed inside and outside the rooms

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- and pointed in such a fashion that only the entry to, and exit from the rooms could be seen, not the patient.
3. The cameras would only be "on" during periods of study, which would randomly cycle from room to room, thus no one would know for sure if the cameras were recording at any given time.
 4. Staff and families could be informed that in these rooms, entry and exit might be video taped for quality improvement purposes.
 5. The video recordings could be analyzed by a multidisciplinary team. High speed video editing equipment could be used to streamline the review process. You could set a minimum number of hours that need to be analyzed for each room, such as 72 hours. You could select study periods when patients were in isolation so you could study isolation practices as well as hand hygiene.
 6. The following data could be gathered:
 - a. Total number of people entering/exiting the room.
 - b. Whenever possible, the identity of person entering and exiting room would be noted.
 - c. The total number of entries and exits during which hand hygiene was done correctly will be noted, as well as the names of those who did and did not following the guidelines.
 - d. The total number of entries and exits from the room during which other isolation techniques were done correctly, such as gown and glove and mask, when indicated.

The fly in the ointment here is what you would do with these data once you had them. Would you report individual compliance rates with hand hygiene guidelines back to individuals? You could just report the data by clinical discipline. If the project were done under the principles of continuous process improvement and a just culture, you could simply report the data back to those involved and then do the study again to see if compliance improved, without (at this stage) attaching any disciplinary or punitive action. Of course, things might get uglier later if the measure-report method did not result in sustained improvements in compliance.

There are a lot of issues to consider here. I have heard some say that this somehow feels like big brother watching. Perhaps that is true, but I think the big brother analogy is faulty. Big brother had very bad motives. If he thought your thinking was faulty, he would strap you to a bed and re-educate you until you were happy to say a 3 was a 4, and indeed you actually came to believe a 3 was a 4. In our case, we are interested in doing our patients no harm by not giving them an infection while they are in hospital, which seems to me to be a pretty honorable goal. I have also heard that this is somehow an invasion of privacy. Whose privacy I ask? If we positioned the cameras so that only door of the room could be seen, we are not invading the patient's privacy. If you are suggesting that we are invading the privacy of the staff I would respond by saying the staff cannot have a reasonable expectation of privacy while they are going in and out of patient rooms.

Besides, in reality you are video taped many times everyday; while you drive, while you shop, while you travel, while you walk down the street and while you stop at the liquor store. Video recording is already used in some hospital settings. Some surgeons record their surgical procedures.

I am sure someone can think of problems with this scheme that I have not considered. But I would like to get a dialogue going about the use of video recordings of care processes for quality improve purposes. It may turn out to be a stupid idea, but hey, sometimes your stupid ideas are some of the only things you can call your very own.

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