

## Letters to the Editor

# Would a rose by any other name really smell as sweet? Framing our work in infection prevention

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*To the Editor*—From consumerism to politics to health care, the way we label or frame an issue plays a huge role in how we understand and respond to it. This is why we now shop for “pre-owned” cars and “dried plums” rather than used cars and prunes and buy “tall” (not small) coffees at Starbucks. Realtors are also excellent at framing. A cottage home seems more marketable when described as “cozy” or “charming” than as “tiny” or “cramped.” Cognitive linguist and professor George Lakoff has pointed out how critical framing is in politics as well, from how initiatives are named (eg, “The Clear Skies Initiative” or “No Child Left Behind”) to how concepts are described (eg, “drilling for oil” vs “exploring for energy” or “undocumented workers” vs “illegal aliens”).<sup>1</sup>

This is also true in the fields of health care and public health. Many tobacco “control” programs began to use the term tobacco “prevention” instead, focusing on the superior aspects and more positive connotation of prevention. The term for “other people’s smoke” has also evolved from “environmental tobacco smoke” (coined by the tobacco industry) to the more commonly used “secondhand smoke,” which proponents argue puts the focus on the exposed nonsmoker.<sup>2</sup> Public health advocates began using the term “car crashes” rather than “accidents” to focus on the fact that most car crashes stem from the preventable results of human error.<sup>3,4</sup>

In health care, we aim to be more inclusive of the changing landscape of our personnel by using terms such as “licensed independent providers” to include nurse practitioners, certified nurse midwives, and physician’s assistants when discussing programs that affect “providers” rather than defaulting to “physicians.” We also attempt to be more accurate in describing our work: for example, “holding units” have become “clinical observation units” because we are providing active care, not simply “holding” patients.

Similarly, the infection prevention community is redefining some of its terms and phrases for several reasons: to place them in a more positive light; to improve compliance; or simply to be more precise, accurate, and inclusive with our language. First,

the term “healthcare workers (HCW)” has been expanded by the Centers for Disease Control and Prevention (CDC) and the Advisory Committee on Immunization Practices to “healthcare personnel (HCP).” The latter term is broader and more inclusive because HCP also includes volunteers and trainees, who are not employees or “workers.” Clearly, pre-exposure prevention (eg, appropriate vaccines) and personal protective equipment (eg, gloves, masks, and gowns) should be made available to all HCP. Antibiotic stewardship is now recommended by both the CDC and the Centers for Medicare and Medicaid Services (CMS). At the University of North Carolina (UNC), we have embraced stewardship activities for many years, but our pharmacy and therapeutics subcommittee is named the “Anti-Infectives Subcommittee” because this group also provides expertise and interventions to improve appropriate use of antifungals, antivirals, drugs used for parasitic diseases, vaccines, and relevant antibody preparations (eg, hepatitis B immune globulin).

Similar to the movement with tobacco control, in recent years there has been a movement to further define our activities to focus on *prevention* rather than control. Thus, our infection control nurses became infection preventionists, and our work moved from “infection control” to “infection prevention.” We are also shifting from the term “chlorhexidine bathing” to “chlorhexidine treatment.” The use of the term “treatment” is part of efforts to increase staff compliance and to reduce patient refusals of the chlorhexidine “bath” by emphasizing its essential role as part of a patient’s medical treatment plan for infection prevention rather than as an optional part of daily care for hygiene.

Finally, we have increasingly moved to using terms that are less negative or pejorative. For example, at UNC, when we perform observations with feedback on our units, we are moving from the term “compliance audits” to “just-in-time coaching.” We have a full-time staff member devoted to bedside coaching with nurses and other HCP. While audits are a fundamental component of quality improvement at our institution, we have come to see that the term itself can create anxiety and other negative reactions. On the same note, some practitioners have begun to use the term “fidelity” rather than “compliance,” which conveys more power and choice to stakeholders. Given that the purpose of our work is to coach staff to follow evidence-based guidelines for infection prevention, we wish to frame this work so that staff view following these guidelines as a decision they make to provide the best patient care possible and see interactions with our bedside coach as a conversation, not as a judgment.

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This brings us back to our titular question derived from Shakespeare: Would a rose by any other name really smell as sweet? We believe the answer is no—our language and framing matter. Being thoughtful in our communication ensures that we are including all our stakeholders, accurately framing our work in a positive light, and correctly describing the work we do—all are critical components of our work in infection prevention.

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# Promoting an action plan for devices in the emergency department—does it impact catheter duration?

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*To the Editor*—Urinary catheters, arterial lines, and central venous catheters (CVCs) are frequently placed in emergency departments (EDs). However, because many devices are inserted for inappropriate and poorly documented reasons,<sup>1,2</sup> physicians on the receiving hospital floors are often unaware of their presence and indication, which can lead to unnecessarily long catheterization.<sup>3</sup> We hypothesized that if the indication and anticipated duration were explicitly stated in the ED discharge report, subsequent care providers would be more aware of these devices in place and could decide more confidently whether to remove them. This information could increase appropriate use, shorten the duration of catheterization, and thereby reduce device-associated complications.

We conducted an intervention study in a 950-bed university hospital in Switzerland, where we included all patients admitted to the hospital with a device (ie, urinary catheter, arterial line, or CVC) placed in our 30-bed ED. Patients with devices placed before ED arrival and patients transferred to another hospital were excluded. We captured data during a preintervention period (July 2016–March 2017) and an intervention period (April–June 2017). Because this study was part of a quality improvement project, no institutional review board approval was required.

During the intervention period, all ED physicians were asked to include in the ED discharge report an action plan for each inserted device with (1) the type of device, (2) the indication for its placement, (3) the anticipated duration. Our infection prevention team held a meeting at the beginning of the intervention, posted indication sheets in the ED work area, and sent weekly e-mail reminders with pertinent information. The timing of this

period was aligned with the baseline surveillance of a national pilot program aimed at reducing urinary catheter utilization and its complications with bundled interventions.<sup>4</sup>

The primary outcome was duration of device placement before and after the intervention. Secondary outcomes were device insertion rates and compliance with the intervention requirements. Electronic health records were used to identify eligible patients and to obtain demographic data including time of device placement and removal. All ED discharge reports during the intervention period were reviewed to determine whether a device-related action plan was proposed. Continuous data are presented as median (interquartile range, IQR), and categorical data are presented as numbers and percentages. We compared continuous variables using the Wilcoxon rank-sum and Kruskal-Wallis tests and proportions using the  $\chi^2$  test. Data analyses were performed using R Studio software.<sup>5</sup>

During the study period, 1,346 devices were inserted in ED patients admitted to our hospital. Most were urinary catheters ( $n=771$ , 57.3%) and arterial lines ( $n=528$ , 39.2%), and a few were CVCs ( $n=47$ , 3.5%). Most patients were male ( $n=805$ , 59.8%) with a median age of 70 years (IQR, 55.0–79.0) and were admitted to the intensive care unit at some point during their hospitalization ( $n=979$ , 72.7%). Table 1 summarizes the catheter durations and their insertion rates. The median duration of urinary catheters was 70.2 hours (35.7–138.0); the median duration of arterial lines was 40.2 hours (20.6–75.4); and the median duration of CVC was 78.8 hours (25.5–163.5). Neither overall duration of catheterization nor that of individual devices decreased over time.

A device was placed in 10.2% of all admitted ED patients. Urinary catheters were placed in 5.9%, followed by arterial lines in 4.0%, and CVC in 0.4% of all patients. Although the overall insertion rates did not change after the intervention, we observed increased use of arterial lines in the intervention period ( $P=.01$ ). During the intervention period, devices were mentioned in 102 ED discharge reports (29.6%); a complete action plan was present in 35 cases (10.1%). The median duration of devices with an

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