



## Research Poster Award

### Use of Documentation in the Patient Record for Interprofessional Communication and Collaborative Decision-making: Implications for the Reduction of CLABSI

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**Problem Statement:** One of the primary purposes of clinical documentation is communication to support interprofessional collaboration and continuity of care. Poor communication has been identified as a major contributing factor to adverse events in healthcare. Recent estimates would make healthcare related harm the third leading cause of death in the United States. One such category of healthcare related harm is healthcare-associated infections. The Joint Commission identified the reduction of healthcare-associated infections, including central line-associated bloodstream infections (CLABSI), as a national patient safety goal for 2015. Efforts to reduce CLABSI have primarily focused on issues related to insertion, with less attention paid to pre-insertion and post-insertion assessment and communication dependencies, such as the prompt removal of lines that are no longer necessary. Shortening dwell time and eliminating the continuance of non-essential central venous catheters (CVC) requires highly functioning interprofessional teams who effectively communicate information related to assessment data, plans, and evaluations. This study was conducted to elucidate what information is used to determine the need for CVC access and/or removal and how this information is communicated between the interprofessional healthcare team. The aim was to identify the necessary components of an informatics tool to support interprofessional communication and facilitate collaborative decision-making regarding the need for CVC access or removal.

**Methods:** This qualitative descriptive study took place in the medical intensive care unit of a large academic hospital. IRB approval was obtained. Semi-structured interviews were conducted with nurses. Interviews were audio-recorded and transcribed, followed by inductive thematic analysis of the data with conformation by research team members.

**Results:** The interviews ranged from 10 to 20 minutes. The eight participants had 6 to 30 plus years of experience, 88% were female, and all but one worked greater than 31 hours per week. Thematic analysis indicated that information related to CVCs is found in disparate areas of the patient record. Verbal discussions are the primary means for exchanging information used in CVC management, and information documented in the record is not regularly used to support collaborative decision-making regarding CVCs. Another theme was the perceived importance of input from the intravenous therapy nurse, who assesses the availability of peripheral access and communicates this verbally to the nurse at the bedside. Also noted was the perception that nurses and physicians differ regarding what factors necessitate CVC access and clinician characteristics influence physician receptiveness to input.

**Significance:** Our findings suggest that no standardized set of documentation informed decisions related to CVC management and that communication occurred verbally during rounds or opportunistically throughout the day. Prior studies have demonstrated that reliance on verbal communication may increase the risk of information loss. Other identified issues from previous work include the interruptive nature of verbal communication, the impact of power differentials, and the underrepresented view of the nurse in verbal exchanges. Reliance on verbal communication may impact poor CVC outcomes and practices, such as increased dwell time and continuance of non-essential CVCs. Further research is needed to understand the impact of communication and documentation practices on CVC management and outcomes.