Problem:
Patients who experience hospital acquired infections have increased mortality, morbidity, increased length of stay in the ICU, increased use of resources, and increased healthcare costs. Our senior leadership made the decision to promote greater patient safety, reduce hospital acquired infections, and promote collaboration in our Medical Intensive Care Units. Our challenge was to implement evidence-based practice in order to reduce and/or eliminate hospital acquired infections while promoting a healthier work environment for all healthcare team members.

Evidence:
The Society for Healthcare Epidemiology of America/Infectious Diseases Society of America, the Centers for Disease Control, the Institute of Healthcare Improvement, and the Leapfrog Group support the implementation of evidence-based practice "care bundles" to reduce hospital acquired infections and promote greater patient safety. According to the Society of Critical Care Medicine patients experiencing life threatening illnesses and injuries have better outcomes when care is provided by physicians who receive additional training in Critical Care Medicine.

Strategy:
In 2007 senior leadership at our urban teaching hospital made the decision to join the Institute of Healthcare Improvement and become members of the Critical Care Collaborative Team. The senior leaders, nurse managers, and staff strongly supported the goal to promote patient safety and improve patient outcomes. This led our facility to embark on a journey to implement an ICU Intensivist Program in 2008. The project has been implemented in the two Medical Intensive Care Units. The Critical Care Collaborative and the Intensivists Program have the mission to promote evidence-based practice (EBP). Our goals are to reduce ICU mortality, overall hospital mortality, promote the utilization of the Rapid Response Team, reduce the number of emergency codes outside the ICUs, reduce the frequency of ventilator associated infections, central line associated infections, hospital acquired pressure ulcers, and reduce associated costs while decreasing the variability in patient care.

Practice Change:
The mechanisms for achieving our goals are the promotion of EBP through daily Multidisciplinary Rounds (MDR) between all healthcare team members, participation on Unit Based Councils, and the Clinical Practice Council. The Multidisciplinary Rounds are conducted 7 days a week with the intensivist, medical residents, critical care nurses, advance practice nurses, a Pharm D, respiratory therapists, registered dietitians, social workers, chaplains, physical therapists, and occupational/speech therapists.

Evaluation:
Process and outcome data are collected daily during the MDRs. The data is compiled monthly in order to trend the changes in our practice as well as the actual patient outcomes related to changes in our practice.
**Results:**
Currently the data demonstrates that the Medical Intensive Care Units have had improved patient outcomes, improved communication, and more collaboration between all members of the healthcare team. The Medical Intensive Care Units have not had a ventilator associated pneumonia, a central line infection, or a hospital acquired pressure ulcer in 5 months. Overall the program has promoted a healthier work environment in the Medical Intensive Care Units.

**Recommendations:**
We recommend greater utilization of our Rapid Response Team, the implementation of the Sepsis Bundle, Glycemic Control strategies, and strategies to prevent urinary tract infections in our hospital. Our future vision includes expanding the program to include our two surgical intensive care units.

**Lessons Learned:**
Changing practice patterns is not as easy as it sounds. It requires diligence and continuous monitoring. The collection of data to verify processes and outcomes is challenging in regards to consistency, standardization, and time allocation. The dynamics of the MDR team offers its own set of challenges. Each team member brings to the table different practice patterns and standards.

**Bibliography**