Hospital Inpatient Quality Reporting (IQR) Program

Support Contractor

Hospital Improvement Innovation Networks and Hospitals Collaboration to Improve Quality of Care: Healthcare-Associated Infections

Questions and Answers Transcript

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Question 1: **On slide 26. How often do you conduct compliance audits? Who completes them?**

The infection preventionist at the hospital tried to do a weekly rounding of maintenance audits. Now, every central line that is inserted has an insertion audit and that goes into the electronic medical record, so that is easy for the infection preventionist to view.

The maintenance audit is one that the infection preventionist really drills down on and she tries to do those weekly. She also wanted to say that part of what the infection preventionist does in the maintenance audits is round on the patient and ask the patient or a family member, “Did the healthcare provider who serviced your line today clean their hands before touching your line and did they scrub the hub for 15 seconds?” Engaging the patient and the family is also beneficial, but again, the infection preventionist strives for weekly audits.

Question 2: **When your intravenous (IV) team entered peripherally inserted central catheter (PICC) lines, are they done at the bedside or in a sterile room?**

The hospital who presented often does them at the bedside. Based on the acuity of the patient, the hospital often establishes a sterile field right there in

the room.

Question 3: **Is there any way to exclude inappropriately tested Clostridium difficile (C. diff) positive patients (asymptomatic)?**

First of all, they really should not test a patient for C. diff that is not actively symptomatic, with six or greater stools a day meeting the (Bristol) stool chart—five, six, or seven in stool characteristics—but it largely depends on how the C. diff is tested. If it is tested via the polymerase chain reaction (PCR) method, you can get inappropriate positives because they are simply colonized and do not have infectious colitis with C. diff. So, the way around that is the new testing that tests the Enzyme immunoassay (EIA) method that tests for infectious toxins.

Question 4: **Do you perform glucose on all patients regardless of history of diabetes?**

Yes. When the hospital implements the (covodine) iodine nasal prophylaxis, yes, but we only do it for orthopedic cases and we also have significant reduction in our surgical site infections (SSIs) there as well.

Question 5: **Have you considered implementation of intranasal povidone-iodine (PVP-I) pre-operation?**

Yes, implemented for orthopedic cases only.

Question 6: **Do you use ultrasound for line insertion and, if yes, do you high-level disinfect the ultrasound probe?**

So, we do not have interventional radiology at hand on my campus. So, no, we do not use ultrasound-guided assistance for the central line insertion, but, if we did, you would high-level disinfect that transducer.

Question 7: **What type of impregnated catheters do you use?**

The Biopatch®, the Ethicon©, and the Curos caps for the alcohol-impregnated catheters. Arrow is the company that manufactures many of the lines that we use. We only use the impregnated as a last resort because you do not want to create resistance with any impregnated indwelling catheter, but Arrow is often the manufacturer of choice.

Question 8: **Slide 24 and 27, how do (you) complete hand hygiene audits?**

We have electronic hand hygiene monitoring in our system. So, any inpatient unit and the emergency department are on an electronic monitoring system. Areas where you cannot effectively conduct electronic monitoring, like the operating room, we do direct observations, but, by and large, we use electronic hand hygiene monitoring.

For central line insertions, it's part of the insertion and maintenance audit and that is done by direct observation when those tasks are being completed and audited.

Question 9: **Follow-up to slide 59: Did you notice any difference between superficial SSI reduction versus deep/organ space reduction? This is great work. Thanks for sharing.**

We observed reduction across all categories of colon SSIs after implementing the advanced colon bundle.

Question 10: **Do you know what type of PICC lines you are using?**

We use Arrow.

Question 11: **When you have an emergency central line catheter insertion and are not able to follow your safety checklist, what special procedures do you take to ensure that patient is monitored further?**

That is a physician's call, but, if you have a sloppily inserted central line, just like a peripheral that is done in the field of a motor vehicle accident or something of that nature, when they arrive at the hospital we remove that line and reinsert a line under sterile ideal conditions. That is what I would recommend—reinserting. If you knew it went in in unsterile or unsafe conditions, I would get it out.

Also, that is the same thing that is recommended with our Foley catheters if they are put in under emergent conditions, central lines under emergent conditions that they will replace after the emergency after the patient has stabilized.

Question 12: **For surgical patients, how long do you monitor and treat post-operation glucose. What is your range, under 180 or 200 for all surgical patients, both diabetes mellitus (DM) and non-DM?**

Metropolitan Hospital continues to monitor these patients as long as their glucoses remain elevated after they start a diet and if they, obviously, did not

have a history of diabetes mellitus preoperatively. These patients will have a medicine consult because we would not want to discharge them home with uncontrolled hyperglycemia.

With regards to the range, in the operating room post-anesthesia care unit (OR PACU), we are using 180 to 200 and, on the floors, we tend to be a little more aggressive and we are covering finger sticks above 151.

Question 13: **Is there a specific recommendation for post-operative incision care?**

So, we don't have a particular dressing that we are using, but we do use sterile dressings for the post-operative dressing changes.

Question 14: **Who (surgeon or nurse) places the post-operative orders on the colon surgery bundle?**

It depends what orders you are referring to (i.e., which specific bundle elements). For glucose control, orders are placed by the physicians for hyperglycemia, which is usually checked for by nursing staff. For the standardized wound dressing—nursing staff. For enhanced recovery after surgery (ERAS) components (e.g., analgesia), it is usually handed by anesthesia.

Question 15: **Was any increase observed in C. diff infections when adding mechanical bowel preparations and oral antibiotics (abx) pre-operatively?**

In hospitals, that have implemented bowel preparation, we have not experienced an increase in C. diff at this time.

Question 16: **Were any of these resources made available?**

All the tools are publicly available. You can find them on www.nyspfp.org, under SSI. Please feel free to visit!

Question 17: **My question is regarding SSI prophylaxis. Have any of the presenters had to modify prophylactic antibiotic selection to address extended-spectrum β-lactamases (ESBLs) or any other multidrug-resistant organisms (MDROs)?**

Many of our hospitals do have prophylaxis for Methicillin-resistant Staphylococcus aureus (MRSA), but not as standard for other MDROs. Many hospitals are screening for MRSA colonization pre-operatively and trying to provide either chlorhexidine gluconate (CHG) or iodophor skin prep in the

patient's home to reduce risk of MRSA-superficial SSI, but may not specifically cover for MRSA in the prophylaxis.

Question 18: **Dr. Pierre, have you had any experience with ESBL colonization and adjusting antibiotic prophylaxis?**

As the Hospital Improvement Innovation Network (HIIN), we do not provide specific guidance on abx prophylaxis, but hospitals do have specific protocols that guide abx prophylaxis. Our understanding is that ESBL is not commonly covered in standard abx prophylaxis. Additionally, it is not something that our hospitals usually screen for and provide prophylaxis for.

Question 19: **Regarding slide 59, are these rates all SSI or just deep/organ space?**

They are all SSIs.

Question 20: **Could we get a copy of the flow sheets?**

If you are talking about the treatment algorithm, I can send those. erik.stpierre@nmmc.org.

Question 21: **Do you have issues with patients tampering with their central lines?**

This is always an opportunity, especially with confused patients. We try to include the patient and family in the education and re-orient as necessary. We make sure to audit dressings regularly and look for tampering. This requires additional assessment than a non-confused patient.

Question 22: **Are the CHG baths using CHG wipes?**

CHG wipes are used for bathing patients with a central line.

Question 23: **Do you use alcohol caps routinely?**

Yes. We routinely use caps; however, that does not change or alter the required scrub-the-hub time.

Question 24: **Regarding C. diff, is it your recommendation to discontinue all other options for cleaning except bleach, if your C. diff rates begin to rise?**

We only use bleach for cleaning C. diff rooms. Our broad-spectrum disinfectant does not have sufficient kill claims against C. diff. Therefore, bleach is our go-to for C. diff. There are other products on the market aside from bleach that are effective against C. diff. Perisept is another option out

there.

Question 25: Can you share the algorithms for the different disease processes you listed for the antibiotic stewardship program?

Please reference the supplemental documentation to the webinar.

- Asymptomatic Bacteriuria
- Hospital Pneumonia Revised
- Hospital Sepsis Revised
- Hospital COPD Revised
- Hospital Cellulitis Revised
- Otitis Revised
- Bronchitis Revised
- Cellulitis Revised
- Pneumonia Revised
- COPD Exacerbation Revised
- Sinusitis Revised
- Pharyngitis Revised
- UTI Revised

(The documentation is located on the last page of this transcript.)

Question 26: How are folks attacking/addressing the inappropriate testing of urine cultures (reflex to culture) in emergency departments (EDs)?

We have set up the ability to order two types of urinalysis orders, one with reflex and one without. We have educated all our providers on the non-treatment of asymptomatic bacteriuria. Please reference the supplemental documentation to the webinar on asymptomatic bacteriuria.

Question 27: Do we keep a patient on enteric contact isolation for the entire duration of the hospital stay even after the patient no longer has C. diff symptoms or after completion of needed treatment?

Patients who have had a positive C. diff polymerase chain reaction (PCR) and are experiencing loose stool will remain on contact precautions 48 hours or a minimum of 48 hours after the resolution of loose stool.

Contact precaution may be discontinued for **swing patients** when the patient returns to their normal bowel movement pattern **and:**

- The patient has been free from diarrhea for 48 hours and the

following criteria is instituted:

- Educate the patient and family about the need to move out of contaminated environment to a clean one. Suggested script*: "Now that you no longer have an active infection, moving you to a clean room and making sure you are freshly bathed/showered will decrease the chance of healthcare workers spreading this bug (C. diff) from this room to other areas of the hospital or other patients."*
- Bathe or shower patient before moving to clean room.
- If the patient is transferred, **ONLY** the patient should be moved; not the bed room furniture or supplies (i.e., basin, dressing, etc.).
- Once in the new room, the nurse or attending physician will discontinue contact precautions.
- Notify housekeeping staff to complete discharge cleaning of the C. diff room.

- Isolation signage must remain in place on doorway of the contaminated room until housekeeping has completed discharge cleaning. Housekeeping will take the sign down and put it in the top drawer of the isolation cart.

OR

If patient cannot be transferred to a new room, the patient will continue contact precautions in existing room until the room change or discharge from the hospital, at which time the room will be terminally cleaned with a bleach-based cleaner.

Question 28: Is there a specific recommendation for post-operation incision care?

Evidence suggests that hospitals should consider standardizing intra-operative application of wound dressing to reduce risk of contamination and maximize wound healing. Dressings should be changed as standard on post-operative day 2 using a clean aseptic technique. Emerging studies indicate negative pressure therapy can be helpful to reduce SSI also. We also suggest that hospitals consider providing instructions for post-operative wound care with specific symptoms to look out for excessive redness/heat/fever/purulent discharge and if these symptoms occur they should seek medical assistance.

Question 29: Does slide 19 include oncology?

We do not have an oncology unit per se, but it would include that population, as they are among the most vulnerable and almost always have a port or venous access device (VAD). We do admit patients with a diagnosis of cancer and, again, they would be included.

Question 30: **Do they include all their physicians in the safety surveys?**

The whole medical staff (physicians) is included.

Question 31: **How does the antibiotic requirement within the SEP-1 measure impact the algorithms the antibiotic stewardship program came up with at your facility? Do you find the two to be in line with one another?**

We developed our inpatient sepsis algorithm to correlate with the SEP-1 measure with regards to antibiotic choice, so it does correlate directly to ensure compliance. Please reference the sepsis supplemental documentation.

Question 32: **Regarding slide 26, can you provide examples of the unit score cards?**

Please reference the supplemental documentation:

- Asymptomatic Bacteriuria
- Hospital Pneumonia Revised
- Hospital Sepsis Revised
- Hospital COPD Revised
- Hospital Cellulitis Revised
- Otitis Revised
- Bronchitis Revised
- Cellulitis Revised
- Pneumonia Revised
- COPD Exacerbation Revised
- Sinusitis Revised
- Pharyngitis Revised
- UTI Revised

Question 33: **When your IV team inserts PICC lines, are they done at the bedside or in a sterile room?**

We insert at the bedside under and established sterile field.

Question 34: **What does your bundle consist of?**

This link is to the Institute for Healthcare Improvement (IHI) central line-associated bloodstream infection (CLABSI) bundle. Click on the PDF document. Page 8 starts to discuss the bundle elements. (www.ihi.org/resources/Pages/Tools/HowtoGuidePreventCentralLineAssociatedBloodstreamInfection.aspx)

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Question 35: **Regarding slide 26, how often do you conduct compliance audits? Who completes them?**

I strive to conduct audits at least weekly. I conduct them and sometimes I bring in an educator or unit resource nurse to help.

Question 36: **Regarding slide 25, with the use of CHG bathing, have you noticed or had concerns with antibiotic resistance, or have you had an increased intolerance to the solution?**

No.

Question 37: **Congratulations on your outcomes! I am curious. Do you practice both the use of a CHG central line dressing and CHG bathing for patients with a central line? The Society for Healthcare Epidemiology of America (SHEA) Strategies for the Prevention of CLABSI states it is unclear whether doing both adds benefit. If so, do you use wipes with CHG or basins and CHG for bathing?**

We use wipes.

For additional information on the topics discussed in this transcript, please refer to the below attachments.