## Timeline

<table>
<thead>
<tr>
<th>Date</th>
<th>Day/time</th>
<th>Task</th>
</tr>
</thead>
<tbody>
<tr>
<td>March 13</td>
<td>Tue 8-10am</td>
<td>Kick-off Meeting</td>
</tr>
<tr>
<td>June 6</td>
<td>Wed 9:30am-12pm</td>
<td>1(^{st}) learning/discussion session</td>
</tr>
<tr>
<td>Sept 26</td>
<td>Wed 9:30am-12pm</td>
<td>2(^{nd}) learning/discussion session</td>
</tr>
<tr>
<td>Dec 12</td>
<td>Wed 9:30am-12pm</td>
<td>3(^{rd}) learning/discussion session</td>
</tr>
<tr>
<td>Mar 13, 2019</td>
<td>Wed 9:30am-12pm</td>
<td>Final learning/discussion session</td>
</tr>
</tbody>
</table>
Long Beach CRE

CRE cases by Month in Long Beach

Number of Cases

- 2017
- 2018
## Long Beach CRE

### Table 1: CRE Organisms Reported in Long Beach, Q1 & Q2 2018

<table>
<thead>
<tr>
<th></th>
<th>Carbapenem-resistant Organism</th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>K. pneumoniae</td>
<td>Enterobacter</td>
<td>E. coli</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Hospital</strong></td>
<td>17</td>
<td>7</td>
<td>1</td>
<td></td>
<td>25</td>
</tr>
<tr>
<td><strong>Skilled Nursing Facility</strong></td>
<td>3</td>
<td>0</td>
<td>1</td>
<td></td>
<td>4</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>20</td>
<td>7</td>
<td>2</td>
<td></td>
<td>29</td>
</tr>
</tbody>
</table>
# Long Beach CRE

## Table 2: Carbapenemase Testing, Q1 & Q2 2018

<table>
<thead>
<tr>
<th>Carbapenemase Type</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Klebsiella pneumoniae carbapenemase (KPC)</td>
<td>3</td>
</tr>
<tr>
<td>Unspecified Carbapenemase*</td>
<td>9</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>12</strong></td>
</tr>
</tbody>
</table>

*Modified Hodge Test*
Long Beach CRE

Source of Specimen: Long Beach 2018 (N=29)

- Wound: 41%
- Blood: 7%
- Unknown: 7%
- Respiratory: 4%
- Urine: 38%
- Retroperitoneal: 3%
Onsite Infection Control Assessments: CRE Prevention Practices and Direct Observations

September 26, 2018
Long Beach CRE Prevention Collaborative
Zenith Khwaja RN, MSN, MPH, CIC
Objectives

- Review evidence-based practices known to prevent healthcare-associated infections (HAI)
- Discuss observed gaps in infection prevention practices
- Review recommendations for monitoring adherence to infection prevention practices
- Review CDPH Adherence Monitoring Tools
- Discuss how to establish a facility-wide adherence monitoring program
HAI Prevention – What works?

Vendor-promoted

Promising

High priority

The newest thing

Kills bacteria

Ritual

Saves time

“I heard it’s effective”

Process change

Eliminates germs

Technology solutions

Saves money

Device upgrade

Reduces colony counts

BEST PRACTICE

“If everything is important, then nothing is”
MDRO Prevention – What works?

- **Evidence-based practice recommendations** are based on science
  - If studied systematically, does a practice result in **reduced infection rates**?
  - To be considered an infection prevention “best practice,” is the practice associated with **sustained** low HAI rates?
  - Careful evaluation of available studies, including risk/benefit, determines recommended practices
  - Where scientifically valid studies are lacking, consensus expert opinion also considered but never alone
HAI Prevention – What works?

• Best sources for evidence-based HAI prevention practice recommendations
  • Centers for Disease Control and Prevention (CDC)
  • Healthcare Infection Control Practices Advisory Committee (HICPAC)
  • Infectious Diseases Society of America (IDSA) / Society for Healthcare Epidemiology of America (SHEA)
HAI Prevention Practice Terms

**Core / Basic Care Practices**
- **Standard of practice**
- Based on higher levels of scientific evidence
- Demonstrated feasibility
- **Effectiveness depends on consistency**

**Special Approaches**
- Used *in addition to Core/Basic* care practices when HAI rates remain high or during outbreaks
- Based on some scientific evidence
- May not be feasible in all settings
Infection Prevention Practices

For Use in All Health Care Settings at All Times

- Visible, tangible **leadership** support for infection control
- Infection prevention **training** for all HCP
- Patient, family, caregiver HAI prevention **education**
- Performance **monitoring** and **feedback**
- Early, prompt **removal of invasive devices**
- Occupational health

- **Standard precautions**
  - Hand hygiene
  - Environmental cleaning and disinfection
  - Injection safety, medication safety
  - Assess risk, use PPE appropriately
  - Minimize potential exposures
  - Clean and reprocess reusable medical equipment

- **Transmission-based precautions** (as necessary)
CDC CRE Toolkit Prevention Strategies

1. Hand Hygiene
2. Contact Precautions
3. Healthcare Personnel Education
4. Minimize Device Use
5. Rapid Laboratory Notification
6. Interfacility Communication
7. Antimicrobial Stewardship
8. Environmental Cleaning
9. Patient and Staff Cohorting
10. Screening Contacts of CRE Patients
11. Active Surveillance Testing
12. Chlorhexidine Bathing
CDC CRE Toolkit Prevention Strategies

1. Hand Hygiene
2. Contact Precautions
3. Healthcare Personnel Education
4. Minimize Device Use
5. Rapid Laboratory Notification
6. Interfacility Communication
7. Antimicrobial Stewardship
8. Environmental Cleaning
9. Patient and Staff Cohorting
10. Screening Contacts of CRE Patients
11. Active Surveillance Testing
12. Chlorhexidine Bathing
Preliminary Results

• Please note that the following information concerning Infection Control assessment data are preliminary- final results may vary and not all infection control assessments have been performed at participating healthcare facilities.
## Contact Precautions

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Are all patients with CRE or other highly-resistant MDRO colonization or infection placed on Contact Precautions?</td>
<td>4</td>
<td></td>
<td>100%</td>
</tr>
<tr>
<td>When multiple residents with CRE are present at the facility, are the primary care-giving staff dedicated to those residents?</td>
<td>3</td>
<td></td>
<td>43%</td>
</tr>
<tr>
<td>Patients at high risk for colonization or transmission of CRE or other highly resistant MDROs are bathed with chlorhexidine on a routine basis</td>
<td>3</td>
<td></td>
<td>30%</td>
</tr>
<tr>
<td>Are patients with CRE either placed in private rooms or cohorted with other CRE patients (if no private rooms are available)?</td>
<td>3</td>
<td></td>
<td>75%</td>
</tr>
</tbody>
</table>
# Communication and Notification

<table>
<thead>
<tr>
<th>Question</th>
<th>Response</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>After identification of CRE or other highly-resistant MDRO, whether preliminary or final, results are communicated to appropriate clinical/infection prevention staff immediately</td>
<td>3</td>
<td>100%</td>
</tr>
<tr>
<td>Are there processes in place that enable you to flag patients previously colonized/infected with CRE or other highly-resistant MDROs upon readmission to your facility?</td>
<td>3</td>
<td>50%</td>
</tr>
<tr>
<td>Is suspected or confirmed CRE or other highly-resistant MDRO status (either colonization or infection) communicated upon admission to your hospital from other facilities?</td>
<td>3</td>
<td>75%</td>
</tr>
<tr>
<td>Is suspected or confirmed CRE or other highly-resistant MDRO status (either colonization or infection) communicated to receiving facilities upon transfer of patients to other facilities?</td>
<td>10</td>
<td>100%</td>
</tr>
</tbody>
</table>
### Risk Assessment

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Are residents with CRE infection/colonization assessed for transmission risk, i.e., degree to which resident might contaminate their environment and the hands/clothing of healthcare workers?</td>
<td>7</td>
<td>0</td>
</tr>
<tr>
<td>Are residents with CRE at high risk of transmission placed on contact precautions?</td>
<td>7</td>
<td>0</td>
</tr>
<tr>
<td>Are residents with risk factors for CRE (e.g., those admitted from high-risk settings) ever screened for CRE?</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Are patients placed on empiric Contact Precautions (i.e., pending results of screening or diagnostic test) when a patient is admitted or transferred from a high-risk setting for CRE or other highly-resistant MDROs, e.g., long-term acute care hospitals?</td>
<td>3</td>
<td>0</td>
</tr>
</tbody>
</table>
### Training and Education

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Have you performed an in-service or similar training session for staff, including EVS, on CRE?</td>
<td>2</td>
<td>7</td>
<td>29%</td>
</tr>
<tr>
<td>Are staff, including physician staff, updated or educated about CRE or other highly-resistant MDRO processes, policies, and protocols?</td>
<td>3</td>
<td>6</td>
<td>75%</td>
</tr>
<tr>
<td>Is there a policy or checklist that environmental services (EVS) follows for cleaning high-touch surfaces daily?</td>
<td>3</td>
<td>6</td>
<td>75%</td>
</tr>
</tbody>
</table>
### Adherence Monitoring

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
<th>Total</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Does your SNF conduct routine adherence monitoring of post-discharge environmental cleaning/disinfection of resident rooms (e.g., via direct observation, ATP bioluminescence, fluorescent marker, or other method)?</td>
<td>3</td>
<td></td>
<td>6</td>
<td>43%</td>
</tr>
<tr>
<td>Does your hospital conduct routine adherence monitoring of contact precautions, HH, EVS.</td>
<td>17</td>
<td></td>
<td>17</td>
<td>85%</td>
</tr>
<tr>
<td>Does your hospital routinely feedback data to unit-level providers on adherence?</td>
<td>17</td>
<td></td>
<td>17</td>
<td>71%</td>
</tr>
</tbody>
</table>
Are Core Infection Prevention Care Practices Performed Routinely?

Results of CDPH HAI Program Liaison IP Observations
Adherence Monitoring Tools for Core Practices

- Hand hygiene
- Safe injection practices
- Blood glucose meter
- **Environmental cleaning and disinfection**
- Device reprocessing
- High level disinfection of reusable devices
- Contact precautions
Keys to Improving Hand Hygiene Adherence

• Visible and easy access to hand washing sinks or hand sanitizer where most needed.
• Sufficient supply of soap at hand washing stations.
• Sufficient supply of paper towels at hand washing stations.
• Sufficient supply of alcohol-based hand sanitizer (e.g. no empty containers).
Hand Hygiene at Skilled Nursing Facilities

Overall Adherence

- Sufficient supply of alcohol-based hand sanitizer (e.g. no empty containers).
- Sufficient supply paper towels at hand washing stations.
- Sufficient supply of soap at hand washing stations.
- Visible & easy access to handwashing sinks or hand sanitizer where most needed.

<table>
<thead>
<tr>
<th>0%</th>
<th>20%</th>
<th>40%</th>
<th>60%</th>
<th>80%</th>
<th>100%</th>
</tr>
</thead>
<tbody>
<tr>
<td>LB CRE Prevention Collaborative</td>
<td>California Facilities</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Overall Hand Hygiene Rates at Acute Care Hospitals

- California Facilities: 70%
- LB CRE Prevention Collaborative: 50%
# Monitoring Hand Hygiene

<table>
<thead>
<tr>
<th>Disciplines</th>
<th>What type of HH opportunity was observed? (select/☑ 1 per line)</th>
<th>✓ Successful</th>
<th>☐ Missed</th>
</tr>
</thead>
<tbody>
<tr>
<td>N</td>
<td>☐ entering room* ☐ before task ☐ after body fluids ☐ after care* ✓ leaving room</td>
<td>✓</td>
<td>☐</td>
</tr>
<tr>
<td>N</td>
<td>✓ entering room* ☐ before task ☐ after body fluids ☐ after care* ☐ leaving room</td>
<td>☐</td>
<td>✓</td>
</tr>
<tr>
<td>CNA</td>
<td>☐ entering room* ☐ before task ☐ after body fluids ☐ after care* ✓ leaving room</td>
<td>☐</td>
<td>✓</td>
</tr>
<tr>
<td>CNA</td>
<td>✓ entering room* ☐ before task ☐ after body fluids ☐ after care* ☐ leaving room</td>
<td>☐</td>
<td>✓</td>
</tr>
<tr>
<td>CNA</td>
<td>✓ entering room* ☐ before task ☐ after body fluids ☐ after care* ☐ leaving room</td>
<td>☐</td>
<td>✓</td>
</tr>
<tr>
<td>CNA</td>
<td>☐ entering room* ☐ before task ☐ after body fluids ☐ after care* ✓ leaving room</td>
<td>☐</td>
<td>✓</td>
</tr>
<tr>
<td>MD</td>
<td>✓ entering room* ☐ before task ☐ after body fluids ☐ after care* ☐ leaving room</td>
<td>☐</td>
<td>✓</td>
</tr>
<tr>
<td>MD</td>
<td>✓ entering room* ☐ before task ☐ after body fluids ☐ after care* ☐ leaving room</td>
<td>☐</td>
<td>✓</td>
</tr>
<tr>
<td>N</td>
<td>✓ entering room* ☐ before task ☐ after body fluids ☐ after care* ☐ leaving room</td>
<td>☐</td>
<td>✓</td>
</tr>
<tr>
<td>N</td>
<td>✓ entering room* ☐ before task ☐ after body fluids ☐ after care* ☐ leaving room</td>
<td>☐</td>
<td>✓</td>
</tr>
</tbody>
</table>

Total # HH Successful ("# ✓"): 4  
Total # HH Opportunities Observed: 10  
Adherence: **40**%  
(Total # HH Successful ÷ Total # HH Opportunities Observed x 100)
Keys to Improving Contact Precautions Adherence

• Ensuring personal protective gear (PPE) is always available where and when it is needed
• Signs Clear and Visible
• Patient in single room or cohorted correctly
• Hand Hygiene before exiting room
Contact Precautions Practices at California Acute Care Hospitals & Skilled Nursing Facilities

- Medical devices disposable OR dedicated to room OR cleaned/disinfected b/w patients
- Gowns/gloves worn on entry
- Gowns/gloves removed, HH performed before exiting room
- Hand hygiene before entering CP room
- Patient in single room OR cohorted correctly
- Contact precautions sign clear and visible
- PPE available at room entry

Skilled Nursing Facilities  Acute Care Hospitals
## Monitoring Contact Precautions

<table>
<thead>
<tr>
<th>Contact Precautions Practices</th>
<th>Pt/Res 1</th>
<th>Pt/Res 2</th>
<th>Adherence by Task</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gloves and gowns are available near point of use.</td>
<td><strong>Yes</strong></td>
<td><strong>No</strong></td>
<td><strong>2</strong></td>
</tr>
<tr>
<td>Signs indicating the patient/resident is on contact precautions are clear and visible.</td>
<td><strong>Yes</strong></td>
<td><strong>No</strong></td>
<td><strong>2</strong></td>
</tr>
<tr>
<td>The patient/resident housed in single-room or cohorted based on a clinical risk assessment.</td>
<td><strong>Yes</strong></td>
<td><strong>No</strong></td>
<td><strong>2</strong></td>
</tr>
<tr>
<td>Hand hygiene is performed before entering the patient/resident care environment.</td>
<td><strong>Yes</strong></td>
<td><strong>No</strong></td>
<td><strong>1</strong></td>
</tr>
<tr>
<td>Gloves and gowns are donned before entering the patient/resident care environment.</td>
<td><strong>Yes</strong></td>
<td><strong>No</strong></td>
<td><strong>2</strong></td>
</tr>
<tr>
<td>Gloves and gowns are removed and discarded, and hand hygiene is performed before leaving the patient/resident care environment. Soap &amp; water if C. difficile infection.</td>
<td><strong>Yes</strong></td>
<td><strong>No</strong></td>
<td><strong>0</strong></td>
</tr>
<tr>
<td>Dedicated or disposable noncritical patient-care equipment (e.g. blood pressure cuffs) is used</td>
<td><strong>Yes</strong></td>
<td><strong>No</strong></td>
<td><strong>2</strong></td>
</tr>
</tbody>
</table>

**Total #Yes** 11  **Total #Observed** 14  **Total #Yes/Total #Observed = ** % Adherence 79 %
Keys to Improving Environmental Cleaning

• Ensure clean, saturated cloth used in each room
• Cloth is changed when visibly soiled and after cleaning bathroom
• Solution in we contact with surfaces according to manufacturers instruction
• Detergent/disinfectant solution mixed to manufactures instructions
Environmental Services at Skilled Nursing Facilities

- New clean, saturated cloth used in each room. Cloth is changed when visibly soiled and after cleaning bathroom.
- Solution in wet contact with surfaces according to manufacturer’s instructions.
- Detergent/disinfectant solution mixed to manufacturer’s instructions.

EV Overall Adherence

LB CRE Prevention Collaborative
California Facilities
Environmental Services at Acute Care Hospitals

- New clean, saturated cloth used in each room. Cloth is changed when visibly soiled and after cleaning bathroom.
- Solution in wet contact with surfaces according to manufacturer’s instructions.
- Detergent/disinfectant solution mixed to manufacturer’s instructions.

Surveyed facilities: California Facilities, LB CRE Prevention Collaborative
# Monitoring Environmental Cleaning

<table>
<thead>
<tr>
<th>Environmental Cleaning Practices</th>
<th>EVS Staff 1</th>
<th>EVS Staff 2</th>
<th>Adherence by Task</th>
</tr>
</thead>
<tbody>
<tr>
<td>Detergent/disinfectant solution is mixed according to manufacturer’s instructions.</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Solution remains in wet contact with surfaces according to manufacturer’s instructions.</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>A new clean, saturated cloth is used in each room. The cloth is also changed when visibly soiled and after cleaning the bathroom.</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Environmental Services staff use appropriate personal protective equipment (e.g. Gowns and gloves are used for patients/residents on contact precautions upon entry to the contact precautions room.)</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Objects and environmental surfaces in patient care areas that are touched frequently* are cleaned and then disinfected when visibly contaminated or at least daily with an EPA-registered disinfectant.</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
</tr>
</tbody>
</table>

# Yes ________  # Observed ____________  #Yes/#Observed = % Adherence ________%
Feedback Results

• Share with unit staff
  • Adherence monitoring results
  • HAI incidence (rates or SIR)
• Present to managers and leadership
  • Use data to focus prevention efforts
  • Use data to get needed resources
SO, HOW DO WE CREATE AND SUSTAIN A STRONG ADHERENCE MONITORING PROGRAM?

September 26, 2018
Long Beach CRE Prevention Collaborative
Teresa Nelson BS RN CIC
Who Recommends Adherence Monitoring?

- Society of Healthcare Epidemiologists of America (SHEA)
- Centers for Disease Control and Epidemiology (CDC)
- Healthcare Infection Control Practices Advisory Committee (HICPAC)
- The Joint Commission (TJC)
- Institute for Healthcare Improvement (IHI)
“Continued progress in healthcare epidemiology and implementation science research has led to improvements in our understanding of effective HAI prevention strategies. Despite these advancements, HAIs continue to affect about 1 out of every 25 hospitalized patients, leading to substantial morbidity, mortality, and excess healthcare expenditures, and there are persistent gaps between recommendations and practice.” (Magill, 2014)
CDC/HICPAC Core Practices, 2017

• Monitor adherence to infection prevention practices and infection control requirements

• Provide prompt, regular feedback on adherence and related outcomes to healthcare personnel and facility leadership

• Train performance monitoring personnel and use standardized tools and definitions
TJC National Patient Safety Goals (NPSG)

Goal 7 - Reduce the risk of healthcare–associated infections

- **Monitor compliance with best practices or evidence-based guidelines**
  - NPSG 07.03.01 – MDRO
  - NPSG 07.04.01 – CLABSI
  - NPSG 07.05.01 – SSI
  - NPSG 07.06.01 - CAUTI
Hand Hygiene- National Patient Safety Goal

• In 2004 surveyors introduced the National Patient Safety Goal (NPSG) 07.01.01
  • Implement a hand hygiene program.
  • Set goals for improving compliance with the program.
  • Monitor the success of those plans.
  • Improve the results through appropriate actions
Individual hand hygiene failures to be cited under Infection Control and NPSG standards

• Taking effect Jan. 1 2018, Standard IC.02.01.01 states, “The [organization] uses standard precautions, including the use of personal protective equipment, to reduce the risk of infection.”

• Any observation by surveyors of individual failure to perform hand hygiene in the process of direct patient care will be cited as a deficiency resulting in a Requirement for Improvement (RFI).
Institute for Healthcare Improvement

“Measuring the results of process changes will tell you if the changes are leading to an improved, safer system. Examples include percent of patient encounters in compliance with hand hygiene procedure and percent of environmental cleanings completed appropriately.”
CDC Elements of Infection Prevention Programs

“The basic elements of an infection prevention program are designed to prevent the spread of infection in healthcare settings. When these elements are present and practiced consistently, the risk of infection among patients and healthcare personnel is reduced.”
What is Adherence Monitoring?

CDC definition

• Audit tools may be used by healthcare facilities to conduct internal quality improvement audits
  
  • **Audit (adherence monitoring):** Direct observation or monitoring of healthcare personnel adherence to job-specific infection prevention measures
  
  • **Feedback:** A summary of audit findings that is used to target performance improvement
**When Should Adherence Monitoring Be Performed?**

- Decide how often to **regularly** conduct adherence monitoring as an **Adherence Monitoring Program**
- Consider monthly adherence monitoring or more often if a unit has high HAI incidence
- Decrease adherence monitoring to quarterly if HAI are low and previous adherence results were high
- Include all shifts
Where is the Best Place to Begin?

• Review Targeted Assessment for Prevention (TAP) reports to focus on units with higher incidence of HAI (CLABSIS, CDI)
  • Engage/train staff on these units to use adherence monitoring tools
• Analyze quarterly SSI data and focus on specific procedures with high SSI incidence (such as hip prosthesis, colon surgery, C-section, abdominal hysterectomy, or appendectomy)
  • Include perioperative staff in the Adherence Monitoring Program
Why is Adherence Monitoring Important?

- Infection prevention policies are most likely in place
- Preventable HAI continue to occur in hospitals
- Even if you have implemented evidence-based recommendations, start monitoring infection prevention care practices to assess if adherence is consistent

You won’t know if you don’t monitor!
How to Establish an Adherence Monitoring Program

• Engage leadership at the beginning
  • Administration champion and physician champion
• Establish the Adherence Monitoring Program as a hospital policy – not an IP Policy
  • NOT the responsibility of the IP or IP department alone
  • Multidisciplinary buy-in and involvement necessary for success
    • Education department, nursing, respiratory therapists, physical therapists, radiology department
• Make it part of the hospital culture
How to Establish an Adherence Monitoring Program

• Include adherence monitoring in manager performance evaluations

• Train all staff performing adherence monitoring using consistent training materials

• Make the Adherence Monitoring Program sustainable by
  • Training staff from every department
  • Require pre-determined scheduled adherence monitoring
  • Feedback results to staff, leadership, and committees

• Validate the adherence monitoring program by having different departments periodically monitor each other
Adherence Monitoring Program Checklist

- Initiate meeting for ongoing participation and support
  - Include chief-level executives and multidisciplinary team members
- Establish as a hospital-wide program
- Develop the hospital Adherence Monitoring Program policy
  - Include all patient care departments
  - Decide where and how often to be performed
  - Compile adherence monitoring tools to be used*
  - Decide how feedback of results will be delivered to staff
- Develop formal training for staff performing adherence monitoring
- Hold a kick-off event to inform staff of program
- Develop a plan for feedback and remediation of identified practice gaps
- Develop a plan to celebrate successes
Simplify the Message – Focus on the Most Important Things

### Preventing CDI: The MOST Important Things

**Prevent C. difficile Acquisition / Reduce Antimicrobial Exposure**
- Isolate patients with diarrhea pending CDI confirmation
- Lab alert system for immediate notification of positive CDI tests
- Contact precautions for duration of diarrhea plus 48 hours
  - Private room, dedicated toilet
  - Gloves/gown to enter room
  - Remove gloves, perform hand hygiene prior to room exit
- Hand hygiene before/after patient contact & after glove removal
  - Patient hand hygiene
- Disposable equipment
- Sporidal disinfectant for cleaning reusable equipment
- Sporidal disinfectant for terminal cleaning
- Quality cleaning, daily & terminal
- CDI-targeted antimicrobial stewardship program
- Improve overall prescribing, stop unnecessary antibiotics
- Restrict high-risk antibiotics based on local epidemiology
- Stop inciting antibiotic

**Prevent Early- and Late-Onset CDI**
- Provide list of indications for central line
- Education of HCP inserting or caring for central line
- Bathe ICU patients with CHG daily.
- Adhere to infection prevention practices at insertion (CLIP)
- Use all-inclusive catheter cart/kit
- Use Ultrasound guidance for insertion
- Use alcoholic CHG skin prep
- Ensure appropriate nurse patient
- Disinfect hub before accessing central line
- Remove nonessential catheters
- Change transparent dressings and site care with CHG every 5-7 days or if soiled
- Replace administration sets not used for blood product or lipids no longer than every 4 days (96 hours)
- Use antimicrobial ointment for hemodialysis catheter insertion sites
- Perform CDI surveillance

### Preventing CLABSI: The MOST Important Things

**Prevent the Devastating Effects of Deep/Organ Space SSI**
- Prophylactic antibiotics
  - Right drug, right dose, right time
  - No doses after incision closed
- Alcohol-based skin prep
- Blood glucose control, all patients
- Normothermia, all patients
- Increased FiO2, if normal function
- Pre-night shower or bath
- Treat other infections
- Smoking cessation at least 30 days
  - No hair removal; if must, clippers
  - Maintain positive pressure ventilation
  - Hand hygiene
  - Surgical attire worn entire time including mask and head cover (covering all head and facial hair)
  - Clean and disinfect all surfaces between cases
  - Flash sterilization only if emergency
  - Sterile dressing for 24-48 hours
Summary

HAI can only be prevented if every HCP adheres to evidence-based practices

You need to know the gaps to correct the gaps

Every care giver needs to own HAI, know how to prevent them, and practice consistently
Questions?

For more information, please contact any HAI Liaison IP Team member

Or email

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