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Joint Commission: New IP compendium guidelines on track to become standards

'A powerful expectation' that hospitals reduce HAIs

The Joint Commission has strongly endorsed recently issued compendium infection prevention guidelines, announcing that the condensed, actionable recommendations may become required as accreditation standards by 2010.



"As of today, the nation's infection control team has a common playbook."
— **Rich Umbdenstock**, American Hospital Association, president and CEO

"In 2009, we will expect all hospitals to review their current practices and their risks and consider which of these [compendium] strategies they need to add," **Robert Wise**, MD, vice president for standards at The Joint Commission, said at an Oct. 8, 2008, press conference in Washington, DC. "Also in 2009, we will convene stakeholders, hospitals, experts in the field, consumers, and government officials to review the entire collection in the compendium to help determine which strategies should be immediately required as part of accreditation. In 2010, we will add these requirements to our accreditation standards. The Joint Commission

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Look for HIC salary survey, career report in January '09

Amid troubling economic times, don't miss our annual salary and career report for infection preventionists in the January 2009 issue of *Hospital Infection Control & Prevention*.

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will continue to create a powerful expectation to take on the problem of hospital infections."

Along with the Joint Commission, *The Compendium of Strategies to Prevent Healthcare-Associated Infections in Acute Care Hospitals* represents a two-year collaborative effort by the Society for Healthcare Epidemiology of America (SHEA); the Infectious Diseases Society of America; the American Hospital Association (AHA); and the Association for Professionals in Infection Control and Epidemiology (APIC). The compendium was published as a supplement to the October 2008 issue of the SHEA journal, *Infection Control and Hospital Epidemiology*.

The compendium is essentially a synthesis of established prevention guidelines to prevent *Clostridium difficile*, methicillin-resistant *Staphylococcus aureus*, central line-associated bloodstream infections (CLABSI), catheter-associated urinary tract infections (CA-UTIs), surgical-site infections, and ventilator-associated pneumonia. **(See related story, p. 125).**

In that regard, many of the infections already have been targeted for prevention in the Joint Commission's recently finalized 2009 patient safety goals. **(See Joint Commission Update for Infection Control supplement in Hospital Infection Control & Prevention, September 2008.)** Asked by *HIC* whether the compendium essentially mirrors the patient

safety goals, Wise said the goals actually were based on the compendium. "The best strategies have never been in one place in an easy-to-use format as they are now," he said. "Immediately, we will join with our partners to rapidly disseminate these practices throughout the country."

Many hospitals already are following the measures recommended by the compendium but there are wide variations in practice even within institutions, he added. "The same hospital that does great at inserting central lines might do poorly at handling urinary catheters, not keeping track of who has them in and [whether] they are being checked daily to see whether they should be withdrawn," Wise said.

'A common playbook'

A key player in the process is the AHA, which can get the attention of hospital administrators and executives. **(See related story, p. 123.)** "As of today, the nation's infection control team has a common playbook," said **Rich Umbdenstock**, AHA president and CEO. "As a partner to this group, the AHA is excited to offer these strategies to the field and will share this important work with

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Grass roots and the C-suite: Two forces drive compendium

The convergence of CEOs and patient advocates

With the recent release of landmark compendium guidelines for prevention of six major health care-associated infections (HAIs), the immediate question is whether these practical, “actionable” guidelines will result in real action. Just because they are condensed, easy-to-use documents, doesn’t mean they won’t sit on a shelf and gather dust alongside their voluminous predecessors.

A favorable sign was that sitting at a press conference table along with the usual suspects in infection prevention were representatives of two powerful forces in health care. Appropriately bookending the panel were patient advocate **Victoria Nahum** — who founded the Safe Care Campaign after the death of her son Josh due to an HAI — and **Rich Umbdenstock**, president and CEO of the American Hospital Association (AHA). Having those two literally at the same table means the grass roots and the C-suite now are eye-to-eye. The human consequences of HAIs are becoming front and center issues for health care executives.

Nahum eloquently reduced a complex issue to a simple emotional context, condensing all the guidelines and strategies even more than the new compendium. “What if it is your — and you can fill in the blank — your young son, your

beautiful daughter, your dear mother, your longtime friend — who is or might become sick or infected or even die from an HAI?” she asked at the press conference in Washington, DC. “Would you insist on [infection prevention] to make sure your loved one would not die?”

Umbdenstock heard the plea, saying “preventing HAIs is a major priority for the nation’s hospitals.” The AHA has the ear of health care executives, who must make that priority a reality within individual institutions if the compendium guidelines are to go from actionable to action.

“I am really pleased to be here to show the connection between the C-suite and the clinical leaders in that partnership that is so important to getting this work done,” Umbdenstock said. “Ensuring an infection-free environment for each and every patient is one of our most daunting challenges. Nonetheless, it is one in which we must succeed.”

Veteran infection preventionists will recall that the AHA dramatically went in the other direction in the mid-1990s, disbanding its infection control advisory panel in a concession to budget demands of the managed care era. **(See *Hospital Infection Control & Prevention*, March 1996 cover story.)** Times have indeed changed, as a confluence of forces usher infection prevention into a new era of transparency and accountability. The grieving mother of a dead patient is knocking on the C-suite door. ■



The Compendium of Strategies to Prevent Healthcare-Associated Infections in Acute Care Hospitals Conference, held Oct. 8, 2008, National Press Club (from L to R): **Patrick J. Brennan**, MD (HICPAC/SHEA), **Victoria Nahum** (Patient Advocate, SafeCare Campaign), **Deborah Yokoe**, MD (SHEA), **David Classen**, MD (IDSA), **Marcia Patrick**, RN, MSN, CIC (APIC), **Robert A. Wise**, MD (The Joint Commission), **Rich Umbdenstock** (AHA).

our national hospitals through our multiple communications vehicles.”

Indeed, having the AHA onboard is seen as a favorable sign that the guidelines actually will be clinically implemented.

“It has to start at the top,” said **Marsha Patrick**, RN, MSN, CIC, an infection preventionist representing APIC at the press conference. “The C-suite sets the tone and I have certainly seen that during my career. We know the best practices, but we have to get them down to the bedside to each and every individual practitioner. Infection prevention efforts must be adequately resourced for us to make these kinds of changes and to be successful in our organizations. Our patients are counting on us.”

Another driver in all this is the Centers for Medicare & Medicaid Services (CMS), which has reduced reimbursement for complications associated with two of the infections included in the compendium: CLABSI and CA-UTIs. “It’s unfortunate that it has taken CMS threatening the withdrawal of reimbursement for some of these activities to get the attention at the C-suite level,” Patrick said. “But, you know, it takes what it takes.”

While there was reference to “federal partners” in the panel discussion, joining CMS on the conspicuously absent list was the Centers for Disease Control and Prevention. That immediately raised the question about possible confusion about standards of care, particularly if any CDC recommendations were at odds those in the compendium. However, **Patrick Brennan**, MD, SHEA president and chair of the CDC’s Healthcare Infection Control Practices Advisory Committee (HICPAC) — the gold standard for infection prevention recommendations — assured *HIC* that would not be a problem. “I don’t have concerns about confusion about the standards given the collaborative nature of the process,” he noted.

Indeed, an editorial accompanying the compendium publication was co-authored by **Michael Bell**, MD, a medical epidemiologist in the CDC division of health care quality promotion and the CDC’s principal liaison with HICPAC.¹ For all practical purposes, the editorial states that the compendium can be used as shorthand for the CDC’s recommendations. “Although there is potential for variability among reviewers in their assessment of recommendation strength or evidence quality, this compendium represents an important tool that facilitates implementation of practices and

procedures to prevent HAIs, complementing official Centers for Disease and Prevention guidelines,” the editorial states.

Moreover, with CDC guidelines often stuck in the limbo of protracted government review, the compendium was actually used to provide updated CDC recommendations. “[T]he compendium delivers updated guidance in areas where official guidelines have revisions pending (e.g., surgical-site infection prevention and urinary tract infection prevention guidelines currently in preparation),” the editorial states. “The compendium published here is a concise, easily applied distillation of current guidelines for the prevention of HAIs that brings together recommendations from respected sources in a format suited to implementation in the clinical setting. . . . As the CDC continues to produce official guidelines in collaboration with professional societies and academic partners, implementation tools such as this compendium will serve as a means to ensure that the best practices for infection prevention are successfully brought to the bedside.”

Strong out of the gate

With a clear stamp of approval from the CDC and the promise of future enforcement by the Joint Commission, the compendium comes out of the gate about as strongly as any infection prevention initiative in recent memory. A new age of transparency, regulation and consumer involvement is certainly pushing such action. Likewise, the ante has been upped by a new wave of clinicians who are showing that tools like simple checklists dramatically can reduce infections once considered inevitable. However, there is another factor that can scarcely be underestimated, the rise of multidrug-resistant and highly virulent strains of pathogens both in the hospital and community. Brennan recalled that he first saw the power of such bugs a decade ago when he lost a patient after a combination of infection and drug contraindications ruled out all available antibiotics.

“An attempt was made to drain the collection of infected fluid from the chest, but the patient died a few days later,” he said. “For me this was an alarming and sentinel event. But imagine the feeling for the patient’s family. A patient had acquired an infection in the hospital, and through

a confluence of events had died without effective treatment as his doctors and nurses stood by helplessly. I didn't encounter such a situation again for a number of years, but now this scenario has become more commonplace. Extremely ill patients, limited therapeutic options, poor outcomes. Prevention is essential."

Given such consequences, the infection prevention community could ill afford to be seen as lost in a maze of its own making. However, a recent government report seemed to be suggesting just that in repeatedly noting that there are a staggering 1,200 individual infection prevention recommendations by the CDC to guide clinicians in protecting patients.² "The report mentions that fact so often that it suggest disbelief that so many recommendations should be necessary to accomplish the task of prevention," Brennan said. "The number does not surprise us who deliver hospital care. The processes that simultaneously support patients and pose a hazard of infection are intricate and must be executed carefully. "

However, given the rising expectations by the public and even within the health care epidemiology community, it was time to err on the side of plain guidance rather than academic equivocation.

"We are now at an important intersection: the translation of public policy into health care reform," he said. "Our health care organizations need additional guidance, not about the knowledge but about the execution of HAI prevention measures. Too often where we fail is not in the knowledge, but in the execution. The compendium is intended to help organizations prioritize the myriad recommendations in order to focus their efforts to safely conduct these processes of care."

Patient advocate **Victoria Nahum** — who founded the Safe Care Campaign after the death of her son Josh due to an HAI — concurred. "We know the right way to proceed," she said. "It's going to take all of us together."

(Editor's note: As this issue went to press, the compendium guidelines were available on the SHEA website at <http://www.shea-online.org/>)

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1. Singh N, Brennan PJ, Bell M. Supplement Article: Editorial. *Primum non nocere. Infect Control Hosp Epidemiol* 2008; 29:S1-S2

2. Government Accountability Office. Health care-associated infections in hospitals: Leadership needed from HHS to prioritize prevention practices and improve data on these infections. Report to the chairman, Committee on Oversight Government Reform, House of Representatives; March 2008. GAO-08-2839. ■

Infection prevention is everyone's business

Administration on hook for resources, staffing

The condensed guidelines in the recently issued compendium for six major infections emphasize administrative responsibility to provide the resources and infrastructure to make the prevention of health care-associated infections (HAIs) a reality. In this landmark new document at least, infection prevention really is everyone's business.

Just to be clear, the compendium is not a regulatory document and the recommendations are not required. However, The Joint Commission already is talking about turning selected recommendations into standards. Moreover, state and federal legislators have shown a continuing interest in turning perceived gold standards of infection prevention into laws. With all the clout behind this document, it becomes a new standard of care by default and an attractive target for future legislation. That gives the sections on infrastructure, staffing, and accountability a certain resonance beyond the typical plea for money to get things implemented.

"We have detailed sections on what kind of infrastructure you need, what kind of personnel to you need, what kind of information technology," said **David Classen**, MD, MS, co-author of the compendium and a consultant in infectious diseases at the University of Utah School of Medicine. "We know these are all challenges implementing the different recommendations. We actually go through the different levels of the organization. What is the responsibility of the CEO? What is the responsibility for the medical staff? What is the responsibility of practitioners?"

For example, on the section on catheter-associated urinary tract infections (CA-UTIs) — the most common HAI — the compendium states, "The hospital's chief executive officer

and senior management are responsible for ensuring that the health care system supports an infection prevention and control program that effectively prevents CA-UTIs and the transmission of epidemiologically significant pathogens. Senior management is accountable for ensuring that an adequate number of trained personnel are assigned to the infection prevention and control program.”¹

Likewise, administration is held accountable for providing the infrastructure necessary to enact the strategies, with the compendium calling for — again in the CA-UTI section — “a system for documenting the following information in the patient record: indications for catheter insertion, date and time of catheter insertion, individual who inserted catheter, and date and time of catheter removal.” Documentation should be accessible in the patient record and recorded in a standard format for data collection and quality improvement purposes, with electronic systems preferred, the guidelines state.

Similar language appears in each compendium section dealing with the other infections, with clinical staff also called out to be accountable. “Direct health care providers [such as physicians, nurses, aides, and therapists] and ancillary personnel [such as housekeeping and equipment-processing personnel] are responsible for ensuring that appropriate infection prevention and control practices are used at all times [including hand hygiene, standard and isolation precautions, cleaning and disinfection of equipment and the environment, aseptic technique when inserting and caring for urinary catheters, and daily assessment of whether an indwelling urinary catheter is medically indicated],” the document states.

Thus, infection prevention responsibilities are spread throughout the staff rather than dumped solely on IPs, who, of course, still are very much accountable to hold up their end of the bargain. “The person who manages the infection prevention and control program is responsible for ensuring that an active program to identify CA-UTIs is implemented, that data on CA-UTIs are analyzed and regularly provided to those who can use the information to improve the quality of care (e.g., unit staff, clinicians, and hospital administrators), and that evidence-based practices are incorporated into the program,” the compendium states.

Though it reaches across all job titles, the compendium was designed in large part with

IPs in mind, said **Deborah S. Yokoe**, MD, MPH co-author of the document and hospital epidemiologist at Brigham and Women’s Hospital in Boston.

“These infection preventionists are my heroes and my role models,” she said at a recent press conference on the compendium. “They are a group of individuals who are incredibly dedicated to the safety of our patients. They will often put in long and even uncompensated hours if they think there is something more they can do to protect our patients from infections. [We] tried to put these recommendations together using a format that is practical. We hope hospitals and very busy health care professionals like the infection preventionists that I work with can translate these infections into actual practice.”

Each section has two levels of recommendations, with one level outlining basic practices and the second listing special measures if problems with the particular infection group continue. The latter group includes “strategies where the scientific evidence of their usefulness in all types of hospital settings isn’t as strong as for the basic recommendations or where benefit has been most demonstrated during an outbreak-type of setting,” Yokoe said. “One example of this is use of chlorhexidine bathing for intensive care unit patients.”

The compendium is designed to provide clarity by clearing the thicket of strategies and recommendations from various sources, opening a path to implementation that more easily translates to day-to-day practice. “I am frustrated often in my practice at the University of Utah when we are [treating] complex patients and are faced with a bewildering set of recommendations from competing guidelines,” Classen said. “As we build this compendium we were very driven by the idea that it really needed to be practical and implementation-focused.”

Other novel aspects of the compendium include an effort to make the recommendations applicable to both children and adults, the inclusion of performance measures to assess effectiveness, and patient educational handouts. “One thing that I think that is unique is that we really emphasize the role of the patient and family,” he said. “That is critical in any successful implementation approach and different from previous initiatives.” **(See patient handout, p. 127.)**

Some sacred cows also were driven to slaughter, as the compendium outlined infec-

(Continued on page 128)

FAQs

(frequently asked questions)

about "Catheter-Associated Urinary Tract Infection"

What is "catheter-associated urinary tract infection"?

A urinary tract infection (also called "UTI") is an infection in the urinary system, which includes the bladder (which stores the urine) and the kidneys (which filter the blood to make urine). Germs (for example, bacteria or yeasts) do not normally live in these areas; but if germs are introduced, an infection can occur.

If you have a urinary catheter, germs can travel along the catheter and cause an infection in your bladder or your kidney; in that case it is called a catheter-associated urinary tract infection (or "CA-UTI").

What is a urinary catheter?

A urinary catheter is a thin tube placed in the bladder to drain urine. Urine drains through the tube into a bag that collects the urine. A urinary catheter may be used:

- If you are not able to urinate on your own
- To measure the amount of urine that you make, for example, during intensive care
- During and after some types of surgery
- During some tests of the kidneys and bladder

People with urinary catheters have a much higher chance of getting a urinary tract infection than people who don't have a catheter.

How do I get a catheter-associated urinary tract infection (CA-UTI)?

If germs enter the urinary tract, they may cause an infection. Many of the germs that cause a catheter-associated urinary tract infection are common germs found in your intestines that do not usually cause an infection there. Germs can enter the urinary tract when the catheter is being put in or while the catheter remains in the bladder.

What are the symptoms of a urinary tract infection?

Some of the common symptoms of a urinary tract infection are:

- Burning or pain in the lower abdomen (that is, below the stomach)
- Fever
- Bloody urine may be a sign of infection, but is also caused by other problems
- Burning during urination or an increase in the frequency of urination after the catheter is removed.

Sometimes people with catheter-associated urinary tract infections do not have these symptoms of infection.

Can catheter-associated urinary tract infections be treated?

Yes, most catheter-associated urinary tract infections can be treated with antibiotics and removal or change of the catheter. Your doctor will determine which antibiotic is best for you.

What are some of the things that hospitals are doing to prevent catheter-associated urinary tract infections?

To prevent urinary tract infections, doctors and nurses take the following actions.

Catheter insertion

- o Catheters are put in only when necessary and they are removed as soon as possible.
- o Only properly trained persons insert catheters using sterile ("clean") technique.
- o The skin in the area where the catheter will be inserted is cleaned before inserting the catheter.
- o Other methods to drain the urine are sometimes used, such as
 - External catheters in men (these look like condoms and are placed over the penis rather than into the penis)
 - Putting a temporary catheter in to drain the urine and removing it right away. This is called intermittent urethral catheterization.

Catheter care

- o Healthcare providers clean their hands by washing them with soap and water or using an alcohol-based hand rub before and after touching your catheter.

If you do not see your healthcare providers clean their hands, please ask them to do so.

- o Avoid disconnecting the catheter and drain tube. This helps to prevent germs from getting into the catheter tube.
- o The catheter is secured to the leg to prevent pulling on the catheter.
- o Avoid twisting or kinking the catheter.
- o Keep the bag lower than the bladder to prevent urine from back-flowing to the bladder.
- o Empty the bag regularly. The drainage spout should not touch anything while emptying the bag.

What can I do to help prevent catheter-associated urinary tract infections if I have a catheter?

- Always clean your hands before and after doing catheter care.
- Always keep your urine bag below the level of your bladder.
- Do not tug or pull on the tubing.
- Do not twist or kink the catheter tubing.
- Ask your healthcare provider each day if you still need the catheter.

What do I need to do when I go home from the hospital?

- If you will be going home with a catheter, your doctor or nurse should explain everything you need to know about taking care of the catheter. Make sure you understand how to care for it before you leave the hospital.
- If you develop any of the symptoms of a urinary tract infection, such as burning or pain in the lower abdomen, fever, or an increase in the frequency of urination, contact your doctor or nurse immediately.
- Before you go home, make sure you know who to contact if you have questions or problems after you get home.

If you have questions, please ask your doctor or nurse.

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tion prevention approaches that should *not* be done. "We did something else unique and unusual in those guidelines [by saying] here are recommendations that have been suggested in other guidelines that really shouldn't be done," Classen said. "We actually outlined the things that we thought the science did not justify."

For example, continuing with CA-UTIs, the compendium cites the following measures as ill-advised. (The ranking and evidence base are cited for each category.):

- **Do not screen for asymptomatic bacteriuria in catheterized patients (A-II).** (*Good evidence to support a recommendation for use. Evidence from ≥ 1 well-designed clinical trial, without randomization; from cohort or case-control analytic studies (preferably from >1 center); from multiple time series; or from dramatic results from uncontrolled experiments.*)
- **Do not routinely use silver-coated or other antibacterial catheters (A-I).** (*Good evidence to support a recommendation for use. Evidence from ≥ 1 properly randomized, controlled trial.*)
- **Do not treat asymptomatic bacteriuria in catheterized patients except before invasive urologic procedures (A-I).**
- **Avoid catheter irrigation (A-I).**
- **Do not perform continuous irrigation of the bladder with antimicrobials as a routine infection prevention measure.**
- **If obstruction is anticipated, closed continuous irrigation may be used to prevent it.**
- **To relieve obstruction due to clots, mucus, or other causes, an intermittent method of irrigation may be used.**
- **Do not use systemic antimicrobials routinely as prophylaxis (A-II).**
- **Do not change catheters routinely (A-III).** (*Good evidence to support a recommendation for use. Evidence from opinions of respected authorities, based on clinical experience, descriptive studies, or reports of expert committees.*)

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1. Lo E, Nicolle L, Classen D, et al. SHEA/IDSA Practice recommendation strategies to prevent catheter-associated urinary tract infections in acute care hospitals. *Infect Control Hosp Epidemiol* 2008; 29:S41-S50. ■

Make patient the focus in meeting CMS regs

Use new requirements to leverage administration

Infection preventionists should continue to make patients their medical and moral compass amid a tightening regulatory environment that includes reimbursement reductions.

Indeed, IPs can use new regulatory demands by the Centers for Medicare & Medicaid Services (CMS) to gain resources and program support from administration and hospital boards, said **Tammy Lundstrom**, MD, JD, a veteran health care epidemiologist and chief medical officer at Providence Park Hospitals in Novi, MI.

"Focus on the patient," she emphasized. "If we always go back to the patient we will make the right decision. Focus on what is what is best for that patient that day. We need to really go back to that and make [decisions based] on what is best for the patient and not necessarily on what we can get paid for and what we won't."

As of Oct. 1, 2008, the CMS has stopped reimbursing for complications associated with certain "preventable" conditions, including the most common health care-associated infection: catheter-associated urinary tract infections (CA-UTIs.)

"Some of the facilities when this first came out said we are going to culture all patients on admission to prove that the UTI was present on admission," Lundstrom said recently in Washington, DC, at an APIC meeting on the CMS changes. "We have a large number of patients with asymptomatic bacteriuria. If we culture for no reason, we are going to get bacteriuria. We all know this from doing UTI surveillance."

A threat to patient safety

That means that an effort to reduce subsequent costs — by showing the condition was not acquired in the hospital and therefore should be reimbursable — actually could endanger patient safety. If patients start testing positive for asymptomatic bacteriuria on admission, the inclination among caregivers will be to provide treatment, she said.

"Most patients don't have a catheter present on admission, so you are adding additional dollars

and unnecessary tests for the patients as well as the possibility of unnecessary treatment with antibiotics," Lundstrom said. "That will increase [drug] resistance and increase the *Clostridium difficile* risk. These are not insignificant risks for the patient, so this approach is out in our facility."

A better approach is to develop a checklist for appropriate indications for placement of urinary catheters, she added. "Educate everybody — nurses, physicians, PAs, medical students, and residents," she said.

By the same token caregivers most know indications for catheter removal so they do not seed infections by being left in indefinitely. Focusing on the patient and preventing the infection essentially takes the reimbursement issue out of the equation, she says.

"The [hospital] board came to me and said, 'How much are we losing on UTIs every year?' and I said, 'I don't care,'" Lundstrom told conference attendees. "I don't care because that does not go with our principle of focusing on the patient. So we are going to report the percentage the catheter insertions that have approved indications and we are going to get to 100%. We are going to report that the percentage of catheters that were removed on the day that indications for use were not longer met — and that is going to be 100%."

Reporting such data underscores the focus on the patient and the fact that not all HAIs are preventable even if all standards of care are met, she said. "If a patient develops a UTI that actually needed a catheter [then] I couldn't have done anything to prevent it," she said. "I provided the right care to the patient at the right time. The fact that I didn't get paid when it happened is immaterial. It is all about the patient. In terms of my day-to-day work, this doesn't impact what I do in infection control in my program, other than I need to be aware of it and use it as an opportunity to talk about prevention."

Indeed, going point-by-point through CMS regulation 482.42 (Condition for Participation: Infection Control), Lundstrom emphasized that IPs should leverage such requirements to strengthen their programs. The CMS regulation requires that there be an "active program for the prevention, control and investigation of infections and communicable diseases," which could be read to do housewide surveillance for everything.

"Does this mean you can not do targeted surveillance? No," Lundstrom emphasized. "An 'active hospitalwide program' doesn't mean

that you can't do targeted surveillance."

Still, the CMS requires that hospitals have to have a mechanism in place to identify and monitor HAIs and communicable diseases occurring in any location and department, she added.

"You don't necessarily need to target everything," she said. "You might have microbiology logs that you review from every area that are available for you to scan. You might develop infection control 'deputies,' unit-based infection control personnel, or clinic based IPs to see what is coming into your clinics. It could be syndromic surveillance of health care workers in terms of respiratory and GI illness. You have to consider [housewide] as part of your risk assessment, but you don't have to monitor everything all of the time."

The CMS also requires a comprehensive prevention and control plan for multidrug-resistant organisms (MDROs). "Do you have to do separate MDRO risk assessment? No," Lundstrom said. "You're overall risk assessment should incorporate MDROs, but this does not mean you have to have a separate written plan for MDROs."

CMS calls for a 'multidisciplinary effort,' giving impetus to efforts to involve physicians and pharmacy in the MDRO program. "It is very important to have a pharmacist as a member of your team to be able to educate physicians on what the resistance patterns are in the facility and what should they be using as empiric antibiotic choices," she said.

Get the board on board

IPs should engage their hospital boards and administration, presenting data and showing prevention efforts. "You've got [a CMS] standard — use it with your administrator to get the attention of the board," she said. "You can use the CMS standards to help you promote your program."

For example, CMS standard 482.42(a) under organization and polices says the hospital "must have adequate resources devoted to the program." The resources should not be based on census alone but also consider scope, complexity and patient characteristics, she emphasized.

"[Say], here's what we did, but here's what we could accomplish with more infection control resources," Lundstrom advised. "Use these standards freely to get the ear of the board and the

ear of administration. Get the resources you need to be able to do even more for patient safety and quality. The most important value of this to me is that it galvanizes everybody in the facility to work in the same direction."

The regulatory era of infection prevention will probably only intensify because patients and their advocates are increasingly demanding action to prevent HAIs. In a personal aside, Lundstrom said the perspective of the patient is understandable if you have a loved one hospitalized. Not known for being shy, Lundstrom is both a physician and an attorney. Yet, she admitted to the audience, she realized how hard it was to enforce hand hygiene when her son was recently hospitalized after a snowboarding accident. "I actually recognized —

even as a health care worker — it's very difficult to really remind other health care workers who come into the room to wash their hands."

Undaunted, she took a seat by the door — between her son and the alcohol gel dispenser. "There was a narrow entry way into the room and I was sitting right [by] the alcohol hand gel dispenser," she said. [I put] my leg out like a swing gate when they came into the room and pointed to the hand gel. It was really hard to force myself to remind people. I was thinking, 'Well, what if they did it outside the room?' But I just put up the 'gate' near the dispenser and they got the hint. One hundred percent of people who touched my child washed their hands — or the gate was not lowered." ■

Readers Write



Shift emphasis from surveillance to action

Focus on counting and reporting bugs 'misguided'

Concerns regarding patient safety have produced numerous pieces of new legislation focused on infection control surveillance and reporting of antibiotic-resistant organisms in healthcare facilities nationwide. National organizations such as the Society for Healthcare Epidemiology of America (SHEA) have published position papers and the Institute for Healthcare Improvement (IHI) has created "bundles" to address the important aspects of an effective infection control program to reduce the spread of antibiotic resistant organisms in our hospitals. Included in these approaches is a focus on the key role that the health care environment plays in transmission of these organisms and the need to ensure adequate cleaning of surfaces and patient care equipment.

In California, [recently passed] SB 1058 calls for more surveillance and reporting to state health departments and increased resources in infection control professionals to accomplish this task. It is questionable as to whether this approach will provide reduction in transmission risk. We propose a shift in focus and in hospital resources away from increased surveillance to increased action. What is

needed are increased FTEs in the housekeeping department so that the necessary amount of time to appropriately clean the environment is allotted. Standardized education and observed competency on optimal cleaning techniques must be made mandatory as is suggested in a recent publication (*Infect Control Hosp Epidemiol* 2008; 29:593-599). Hospital administrators need to be aware of the key role that the Environmental Services staff play in the infection control aspect of patient safety. None of us wants to be the patient placed into a room that has not been adequately cleaned.

In January 2004, California AB 394 required minimum nursing staffing ratios to improve patient safety. Unfortunately, this resulted in a reduction of the use of certified nursing assistants. With fewer nursing assistants available, it is less common for tasks such as cleaning of unit-based equipment and patient hygiene to be accomplished. Effective control of the spread of infection — patient safety — has been compromised. Nursing assistants play a vital role in the infection control program.

Transmission of antimicrobial resistant organisms is only one component of the antimicrobial resistance crisis. Prudent use of antibiotics by clinicians and "antibiotic stewardship" within our health care facilities has long been known to be an effective method to reduce risk of antimicrobial resistance. To date, we have not seen legislation that focuses on that key element.

Counting and reporting the number of antibiotic-resistant organisms within our health care facilities is a misguided use of resources. It will not provide us with the immediate improved outcomes that we and the public desire. The rates of transmission will only be reduced by taking

immediate action to increase the use of support staff to perform optimal cleaning and hygiene protocols and consistent application of protocols for prudent antibiotic use in our health care facilities.

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CNE/CME instructions

Physicians and nurses participate in this CE/CME program by reading the issue, using the provided references for further research, and studying the questions. Participants should select what they believe to be the correct answers, then refer to answer key to test their knowledge. To clarify confusion surrounding any questions answered incorrectly, please consult the source material. After completing the semester's activity, you must complete the evaluation form that will be provided and return it in the reply envelope to receive a credit letter. ■

CNE/CME answers

17. A; 18. B; 19. D; 20. D.

CNE/CME objectives

After reading each issue of *Hospital Infection Control*, the infection control professional will be able to do the following:

- identify the particular clinical, legal, or educational issue related to epidemiology;
- describe how the issue affects nurses, hospitals, or the health care industry in general;
- cite solutions to the problems associated with those issues, based on guidelines from the federal Centers for Disease Control and Prevention or other authorities, and/or based on independent recommendations from clinicians at individual institutions. ■

CNE/CME questions

17. The Joint Commission strongly endorsed recently issued compendium infection prevention guidelines, announcing that the condensed, actionable recommendations may become required as accreditation standards by 2010.
- A. True
B. False
18. The compendium is essentially a synthesis of prevention guidelines to prevent six health care-associated infections. Which of the following infections was not included in the document?
- A. *Clostridium difficile*
B. Vancomycin-resistant enterococci
C. Central line-associated bloodstream infections
D. Surgical-site infections
19. Concerning catheter-associated urinary tract infections, the compendium recommended which of the following:
- A. Screening for asymptomatic bacteruria in catheterized patients.
B. Routinely using silver-coated or other antibacterial catheters
C. Performing frequent catheter irrigation.
D. None of the above
20. Which of the following were cited as possible problems with culturing patients on admission to determine a pre-existing urinary tract infection?
- A. Patients may have asymptomatic bacteriuria.
B. Could lead to unnecessary treatment.
C. Use of antibiotics could increase risk of *Clostridium difficile*.
D. All of the above

COMING IN FUTURE MONTHS

■ Joint Commission infection-related sentinel events

■ Assessing the program impact of CMS changes

■ Federal IP regulation on horizon

■ IPs and patient advocates: A marriage made in . . .

■ SSI post-discharge surveillance: Who's doing it right?

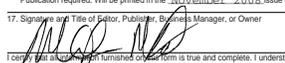
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