

Note: New CNE procedures.  
See p. 83 for details.

# Hospital Infection Control & PREVENTION

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July 2011

Volume 38, No. 7

Pages 73-84

## CMS planning infection control inspections of U.S. hospitals

Is 'pay for prevention' on the horizon?

By **Gary Evans**, Executive Editor

The Centers for Medicare and Medicaid Services (CMS) — the single largest payer for health care in the United States — is creating a hospital inspection program focused specifically on infection control, *Hospital Infection Control & Prevention* has learned.

*Hospital Infection Control & Prevention* has learned.

"We have a problem in this country with far too many infections and too many deaths due to infections in hospitals," said **Daniel Schwartz**, MD, MBA, chief medical officer of the Survey and Certification Group at the CMS. "So what can we do to fix this? I don't think it's necessarily CMS alone that is going to fix this, but a hospital should be able to detect when they have a problem — they should have systems in place to recognize and fix those problems."

It doesn't take a great leap of imagination to see this fledging survey concept eventually morphing into CMS "pay for performance" requirements, though the program is being pitched initially as a non-punitive collaborative that can help hospitals improve quality. In the boldest move yet in its dramatically expanding oversight of infection prevention, the CMS is planning to train a cadre of inspectors to assess basic infection control measures and follow single hospitalized patients using a "tracer" concept similar to that used by Joint Commission (TJC) surveyors. The CMS program was discussed recently in Atlanta at a meeting of the Centers for Disease Control and Prevention's Healthcare Infection Control Practices Advisory Committee

**With the death of 100,000 people annually due to HAIs, critics have been saying for years that the CMS should use its considerable influence on the hospital bottom-line to put some teeth in the CDC's voluntary infection control guidelines.**

### In This Issue

- ❑ **IPs can leverage the mandate:** CMS plans to inspect hospitals for infection control just made your program more important . . . . . cover
- ❑ **CMS going beyond ASC survey:** Expect the elements on hand hygiene, needle safety, sterilization to be included though . . . . . 76
- ❑ **Q&A on new Patient Partnership:** CMS initiative means this group is not kidding around. . . . . 77
- ❑ **APIC Conference Coverage**
  - Besieged unit 'owns' the problem, drives CLABSIs to zero. . . . . 78
  - How to use duct tape to save \$100,000. . . . . 79
  - UTIs kicked out of rehab . . . . . 80
- ❑ **OSHA inspecting too:** Targeting outpatient centers for needle safety devices . . . . . 81
- ❑ **Endoscopy update:** SHEA and ASGE issue revised endoscopy reprocessing guidelines, reassure public about rare infections . . . . . 82



**Financial Disclosure:**  
Executive Editor Gary Evans, Consulting Editor Patrick Joseph, MD, and Katherine West, Nurse Planner, report no consultant, stockholder, speaker's bureau, research, or other financial relationships with companies having ties to this field of study.

(HICPAC).

"Obviously, if we are writing regs and you are writing guidelines, we really want to be on the same page," Schwartz told the HICPAC panel. "We want this to have a major impact on infection control and help reduce health care associated infections."

There is a clear precedent for partnership. In the wake of continuing hepatitis outbreaks in ambulatory care settings — most of them linked to improper use of needles and medication vials — the CMS worked with the CDC to create an infection control checklist to use for inspecting outpatient facilities. (See *HIC Dec. 2008; related story p. 76*) Though such flagrant needle practices are rarely found in hospitals, CMS inspectors would likely look for such breaches while assessing basic principles like hand hygiene, barrier precautions, instrument processing and the like.

As discussed at the CDC meeting, the CMS will create a hospital infection prevention survey that will be reviewed by HICPAC, other key stakeholders and possibly opened for public comment. The survey will be "pre-tested" in selected participating hospitals, with an emphasis on using it as a self-assessment tool to improve infection control practices. In that sense, the CMS appears to be trying to launch this inspection process without incurring a lot of pushback from hospitals. For their

part, infection preventionists are viewed as an important part of the process and could leverage the CMS involvement into upgraded program resources.

"We want to go into the hospitals and use [the survey] to see what works and what doesn't, get feedback and really make it better," Schwartz told *HIC*. "In the end we want everybody to be kind of happy with it. We want it to be, obviously, something the surveys find to be useful and we want it to be an assessment opportunity for the hospitals. We want them to be comfortable that if they do these things, not only will they do well on the surveys but they might be able to [prevent more HAIs]."

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### Codifying CDC guidelines

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With the death of 100,000 people annually due to HAIs, critics have been saying for years that the CMS should use its considerable influence on the hospital bottom-line to put some teeth in the CDC's voluntary infection control guidelines. However, Schwartz rejected that analogy in an interview with *HIC*, saying the CMS was charged to create the hospital inspection program as part of the newly formed Partnership with Patients. This recently announced federal, state and private collaborative will focus on improving patient safety

**Hospital Infection Control & Prevention**®, including **Infection Control Consultant**™ and **Healthcare Infection Prevention**™ (ISSN 0098-180X), is published monthly by AHC Media, a division of Thompson Media Group LLC, 3525 Piedmont Road, Building Six, Suite 400, Atlanta, GA 30305. Telephone: (404) 262-7436. Periodicals Postage Paid at Atlanta, GA 30304 and at additional mailing offices.

**POSTMASTER:** Send address changes to **Hospital Infection Control & Prevention**®, P.O. Box 105109, Atlanta, GA 30348.

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This activity is effective for 36 months from the date of publication.

Target audience: Infection control practitioners and infectious disease physicians.

Opinions expressed are not necessarily those of this publication. Mention of products or services does not constitute endorsement. Clinical, legal, tax, and other comments are offered for general guidance only; professional counsel should be sought for specific situations.

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### Editorial Questions

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by reducing healthcare associated infections (HAIs) and other hospital-acquired conditions. (See related story, p.77)

"[In terms of the] state of the art in the field I can't think of a better organization, and one that has a better reputation in infection control than the CDC," he told *HIC*. "it really helps to have this working arrangement with them so that was our starting point [for this survey]. We have thought about doing something like this anyway because we have been dealing with [ambulatory surgery centers] and we have conversations [with the CDC] all the time about infection control issues."

Whatever the program's origin, the future result — possibly within the next year — could see CMS inspectors making fairly thorough visits to hospitals. "This will probably involve two surveyors over two days to do the assessment," Schwartz told HICPAC. "We are hoping to make this an easy to use tool that is highly effective."

While CMS usually comes into hospitals only to respond to specific complaints, the scale of the program discussed at the meeting would be much more ambitious in terms of oversight and routine inspection. "When CMS goes into hospitals most of the time the reason is a compliance investigation and we do maybe 4,000 to 5,000 of those — but that's a very limited survey," he said.

The hospital survey initiative certainly reflects the influence of new CMS chief **Don Berwick**, MD, a longtime health care quality and transparency advocate. Under Berwick, the CMS has continued to step up fiscal pressure on hospitals to adopt quality measures and best practices to reduce HAIs. In an interview prior to his CMS appointment in July 2010, Berwick said he hopes the public "gets a bit outraged and mobilized as voters," he said. "[They should] ask why we pay systems the amount of money we are and not have them adopt the best practices."

In that regard, liaison HICPAC member **Lisa McGiffert**, senior policy analyst on health issues at the Consumers Union, expressed strong support for the CMS initiative.

"This [survey] tool is very important," she said. "I do agree [it can be used] for hospitals to have help in improving care, but I think ultimately it's [CMS'] responsibility that the environment is safe for patients. You are not there just to help the hospitals."

In particular, McGiffert urged the CMS to

ensure that hospitals are tracking and reporting all infections, something that has been questioned as more and more states mandate rate data.

"We do touch on that in the interview portion of it," said **Carolyn Gould**, MD, a CDC medical epidemiologist who is collaborating on the CMS project. "There are a lot of questions related to the infection prevention program and resources, and that includes surveillance."

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### *How will CMS address diverse settings?*

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While generally open to the concept, several HICPAC members pointed out the wide differences in types of hospitals and the possible detrimental impact of such inspections on smaller hospitals with scarce resources. Schwartz said the CMS is not developing a "one-size fits all" tool, but in any case the basic infection control principles apply across the continuum.

"If you put a tracer on almost any patient and procedure the surveyor is going to be looking at hand hygiene, injection safety [and] basic infection control at the bedside," he told the CDC panel.

The Joint Commission's experience with the tracer technique in the survey process indicates that the CMS will have to be prepared to conduct ongoing training of inspectors, noted HICPAC liaison member **Robert Wise**, MD, vice president of the division of standards and survey methods at TJC.

"We have been at this [patient tracer] for about seven years," he told Schwartz during the HICPAC discussion. "You may know or you will soon know that in the initial startup there is a huge amount of variability. It takes a lot of training — there is a constant amount of overhead involved in training. We can stay in close contact with you about that — seven years [reflects] a lot of good and bad experiences — but we certainly applaud you going in this direction, even though it is fraught with a number of methodological issues."

Noting that the CMS was "open to suggestions," Schwartz characterized the training issue as a legitimate challenge that could nevertheless be met.

The bottom-line is that "there isn't a hospital in the country that doesn't want to provide a safe environment for their patients and make sure they do everything possible to prevent transmission of infectious diseases," he said.

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## *A gap analysis tool*

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In that regard, the CMS survey and inspection process could ultimately serve as a "gap analysis" tool for hospitals to ensure infection control is a facility priority. "This would be available to hospitals as a self assessment," Gould

said. "It would be a way for hospitals to survey themselves prior to [CMS] surveys so they can be better prepared."

Veteran infection preventionist and HICPAC consultant **Judene Bartley**, MS, MPH, CIC, underscored the importance of ensuring the CMS survey is based on scientific evidence as

# CMS tool for hospitals will go beyond ASC survey

*Hand hygiene, needle use likely included*

A survey tool to assess infection control in ambulatory surgical centers (ASCs) was created by the Centers for Disease Control and Prevention for use by inspectors for the Centers for Medicare & Medicaid Services. As the two agencies discuss creating a similar tool for hospital inspections, an expansion beyond the ambulatory care model is expected. That survey tool included some basic environmental cleaning, disinfection and sterilization requirements along with soliciting a "yes" or "no" response in the following areas:

### **I. Hand Hygiene**

- A. Soap and water are available in patient care areas
- B. Alcohol-based hand rub is available in patient care areas
- C. Staff perform hand hygiene:
  - a. Before and after an invasive procedure (e.g., insertion of IV catheter, intubation/extubation, surgical procedure) even if gloves are worn
  - b. After contact with blood, body fluids, or nonintact skin (even if gloves are worn)
  - c. After contact with used, contaminated medical equipment or visibly contaminated environmental surfaces (even if gloves are worn)

**Note:** To ensure consistency between site visits, hand hygiene should be observed during the "follow-through" of patients from arrival to discharge, with particular attention paid to invasive procedures.

- D. Regarding gloves, staff:
  - a. Wear gloves for procedures that might involve contact with blood or body fluids
  - b. Wear gloves when handling potentially contaminated patient equipment
  - c. Remove soiled gloves before moving to next task
- E. If a surgical scrub is required, the surgical team performs surgical hand scrub

### **II. Injection Practices (medications, saline, other infusates)**

- A. Needles and syringes are used for only one patient
- B. Injections are prepared in a clean area that is free from contamination with blood, body fluids, other visible contamination, or used contaminated equipment
- C. The patient's skin is prepped with an anti-septic before IV placement
- D. List all injectable medication/infusates that are in a vial/container used for more than one patient. This should include the medication name, size of vial (cc/mL) and the typical dose per patient (cc/mL)
- E. Single-dose medications/infusates are used for only one patient and not collected or combined (bags of normal saline are ALWAYS single use)
- F. Multidose medications/infusates are used for only one patient (note: a "No" answer here is not necessarily a breach in infection control. Circle N/A if no multidose medications/infusates are used.)
- G. Medication vials used for more than one patient are always entered with a new needle and new syringe
- H. The rubber septum on a medication/infusate vial is disinfected with alcohol prior to piercing after initial entry
- I. Medications/infusates that are packaged as prefilled syringes are used for only one patient
- J. Medications/infusates are drawn up at start of each procedure
- K. Fluid infusion and administration sets (e.g., intravenous bags, tubing, and connectors) are:
  - a. Used for one patient only
  - b. Disposed of after use
- L. Needles and syringes are discarded intact in an appropriate sharps container after use. ■

CDC interpretive guidelines are reduced and condensed. “[I like] the whole idea of using this as a self-assessment tool that could help train the newbies that haven’t done this before,” she added.

The considerable tasks ahead include honing down the infection control areas or “modules” to be assessed, as a basic checklist of CDC recommendations came to 22 pages, Schwartz told the panel. Various suggestions for inclusion by HICPAC members included infection control during care transitions and hospital employee health.

“There will be some questions on occupational health, when you get a chance to look at the tool — in whatever form it comes out in the next couple of months — take a look at those sections and tell us what we can do to make it better,” Schwartz said. “We can’t always use everything [HICPAC] puts out, and to a certain degree that is unfortunate, but we have to work with the regs as they are written. We will try to use as much as we can.” ■

## Patient partnership hits ground running

*Initial focus is on acute care hospitals*

The Centers for Medicare and Medicaid Services is creating an infection control inspection survey for hospitals as part of its participation in the recently formed Partnership for Patients. Here is some basic Q & A information on the diverse alliance, with more available at <http://1.usa.gov/gj8iFV>.

**What is the Partnership for Patients?** The Partnership for Patients brings together leaders of major hospitals, employers, physicians, nurses, and patient advocates along with state and federal governments in a shared effort to make hospital care safer, more reliable, and less costly. To help achieve these goals, public and private partners will develop models to deliver better care for patients that can be shared widely. The two goals of this new partnership are to:

- Keep patients from getting injured or sicker. By the end of 2013, preventable hospital-acquired conditions would decrease by 40% compared to 2010. Achieving this goal would mean approximately 1.8 million fewer injuries to patients with more than 60,000 lives saved

over three years.

- Help patients heal without complication. By the end of 2013, preventable complications during a transition from one care setting to another would be decreased such that all hospital readmissions would be reduced by 20% compared to 2010. Achieving this goal would mean more than 1.6 million patients will recover from illness without suffering a preventable complication requiring re-hospitalization within 30 days of discharge.

**Who will the Partnership for Patients help?** First and foremost, the Partnership for Patients is designed to help patients and their families. Everyone involved is committed to dramatically reducing the number of Americans who get injured or become sicker in the hospital, or suffer from preventable complications during a transition from one care setting to another.

Achieving the goals of the Partnership for Patients would mean approximately 1.8 million fewer injuries to patients with more than 60,000 lives saved over three years. It would also mean more than 1.6 million patients will recover from illness without suffering a preventable complication requiring re-hospitalization within 30 days of discharge.

The Partnership for Patients will also support hospitals and the nurses, doctors, and other professionals who work in them providing health care. No one ever wants to see a patient get hurt or become sicker in the hospital — certainly not those who have devoted their lives to healing. The Partnership for Patients will support health care providers in achieving their most important goal: taking the best possible care of their patients.

**How much will the Partnership for Patients cost? Who is paying for it?** Nearly one in seven Medicare beneficiaries is harmed during the course of their care, which costs the government nearly \$4.4 billion in health care spending. The personal costs to patients of extended hospital stays and time away from work is untold. The status quo costs a lot — and it is unsustainable for Medicare, for employers, and for the budgets of patients and their families.

To address this very costly problem, the Department of Health and Human Services will use \$1 billion made available through the Affordable Care Act. Other members of the Partnership for Patients — private and public —

may choose to devote additional resources to supporting care improvement in their own settings. Achieving these goals will save lives and prevent injuries to millions of Americans, and has the potential to save up to \$35 billion dollars across the health care system, including up to \$10 billion in Medicare savings, over the next three years. Over the next ten years, it could reduce costs to Medicare by about \$50 billion and result in billions more in Medicaid savings. This will help put our nation on the path toward a more sustainable health care system.

**How will safety issues outside of hospitals be addressed?** Patient safety is essential in every care setting. Initially, the Partnership for Patients focuses primarily, but not exclusively, on acute-care hospitals because of the strong evidence base around harm reduction in that setting, the pending payment changes on the horizon for acute-care hospitals, and a broad shared will across the stakeholder community to address the problem, thanks to decades of awareness-raising. The Partnership for Patients also focuses on care transitions, which link patients between acute-care settings and long-term care, rehabilitation, or their homes. Efforts identified to reduce readmissions will focus on ensuring that patients get the right care as plans are made for their discharge and post-discharge period. Working with hospitals, community-based organizations, patients and families to reduce readmissions is one of the Partnership's two central goals and will affect care quality and patient safety across the care continuum. ■

## APIC CONFERENCE

### 'Owning' the problem drives CLABSIs to zero

*Saving a few lives and a cool quarter mill*

There has been so much hoopla about driving central line-associated bloodstream infections (CLABSIs) down to zero with checklists and bundles, that a unit that fails to achieve such success may take it somewhat personal. After a period of struggle, nurses on a surgical intensive care unit (SICU) at a large academic medical center did just that, deciding to "own the problem" until they cut bloodstream infections

to zero and saved more than \$200,000 during a six-month period.

Ultimately, culture change in a given unit may be as big a factor as any checklist or infection prevention tactic, said **Michael Anne Preas**, RN, BSN, CIC, infection preventionist at the University of Maryland Medical Center in Baltimore.

"It was truly a back-to-basics effort – these were just best practices at a granular level, led by the unit themselves," she said recently in Baltimore at the annual educational conference of the Association for Professionals in Infection Control and Epidemiology. "The nurses on the unit took ownership of best practices and drove the change. When you have one of your own in the lead, and are reminding each other and encouraging each other to do your best, everybody gets on board, and that is what we saw."

Preas played a key role in the project, but credits the culture change within the unit for making a change that will endure.

"Until the staff actually owned doing that work, they were struggling with their [infection] rates," she said. "We are using this as a business case to make sure that the units are well staffed, so that they can do the work of infection control. I'm the one who got the publicity for being the germ cop, but really this whole concept of going around and saying 'You're doing this correctly or incorrectly' [has diminishing returns]. One IP can make an impact, but can't make the difference in the way the unit can by changing their own internal culture."

Morale was not so high at the outset, as the unit staff were coming to terms with the thought that maybe there was little more they could do for their patients. "We had a CLABSI rate [in this unit] that was significantly higher than the national average," she said. "They had many best practices in place – they used the standard central line cart for all of the placement of their catheters. They used sterile barrier precautions when they inserted these lines and used a checklist."

When infections continued to occur, there was some thought that the patient severity of illness in the SICU was too high to overcome with interventions.

"Frankly, the staff in this particular SICU believed that they could not get to zero," Preas said. "They felt that their patients were too sick

*continued on p. 80*

# APIC CONFERENCE

## IPs save over \$100,000 by using ... duct tape?

*'Red Box' concept improves care of iso pts*

OK, maybe duct tape really can fix everything. A simple red roll of this prime tool in the kit of every weekend repairman led to some rather startling results for innovative infection preventionists. The tape was used as an inexpensive solution to the costly and time-consuming problem of communicating with hospital patients who are isolated on contact precautions for infections at Trinity Medical Center in the Quad Cities on the Iowa/Illinois border.

The 504-bed Midwestern health system saved up to 2,700 hours in work time and \$110,000 a year by creating a "Red Box" safe zone, a three-foot square of red duct tape extending from the threshold of the door, to facilitate communication with patients, said **Janet Nau Franck**, RN, MBA, CIC, an infection prevention consultant for the facility.

"The IP team noticed declining compliance of staff wearing gowns and gloves when entering an isolated patient's room," she said recently in Baltimore at the annual educational conference of the Association for Professionals in Infection Control and Epidemiology. "They also noted that staff was less likely to enter the room if they had to wear gowns and gloves. After some research and soul searching, they realized that no documented risk existed when communicating near the door's entrance. So they set out to the local hardware store, returning with red duct tape in hand."

By using this taped-off safe zone, the hospitals were able to save time, money in unused gowns and gloves, and improve the quality and frequency of communication between health care workers and isolated patients. Typically, workers must don personal protective equipment (PPE) before entering an isolated patient's room before any type of communication. Dressing in gowns and gloves before each interaction is time-consuming, costly and creates communication barriers with patients. Moreover, the hindrance of donning the equipment may be

a disincentive for workers to enter the room.

"Once they cross out of the box then they are required to don the appropriate PPE — the gear is on the door," she explained. "They would wear gown and gloves if they step out of the red box into the patient's room.

There is no documented evidence that there is any risk of transmission from the door. This study was evaluated for the use of contact precautions, but originally we were thinking it is certainly greater than three feet from the head of the patient bed. Realistically — although it was not studied — it could be used for droplet precautions."

The study showed that workers could safely enter the Red Box area without PPE for quick communication and assessment. At Trinity, approximately 30% of interactions with patients on contact precautions were performed in the box. In a worker survey, 67% of health care staff said that the approach lessened barriers when communicating with patients. Also, 79% reported that the box saved time in not having to put on and remove PPE. The same number said healthcare workers could assess and communicate with patients more easily. The box also serves as an additional visual cue to remind staff that they are entering an isolation room, which is usually only indicated by a sign outside the patient's room, she noted.

"It is a green initiative that saves money [in supplies] and also over 2700 hours — if you calculate it on an annual basis — which would exceed a fulltime equivalency of another staff person," Franck said.

Asked if such a program could be a proverbial slippery slope — introducing the idea that workers can enter an isolation room without PPE — Franck said compliance is assessed frequently in rounds. "The compliance has been about 98% and we are seeing that the staff is much happier because they don't always have to don the PPE." ■



*continued from p. 78*

and that they were doing everything they could and this was the best it was going to be. So we kept having conversations with them and eventually last spring we had a meeting and this particular unit decided they were going to take over and own infection control in their unit.”

To address the problem of higher-than-average CLABSI rates on the 19-bed unit, the hospital appointed dedicated infection control nurses (ICNs) to oversee central line catheter insertions. The effort was conducted in partnership with the director of medical surgical nursing. An ICN was present during every central line insertion and trained to call out breaks in technique, breaches in hand hygiene and to perform daily assessment of central line dressings, looking for signs of infection. The nursing staff came up with clever reminders for best practices and created incentive programs to keep the team motivated and engaged. They also removed excess clutter from patient rooms and hallways so it would be easier to clean them.

To kick off the intense focus, staff huddled for a five minute education session on best practices every day, eventually extending this time to cover other infection control issues. “What was so exciting was that almost immediately we began to see no CLABSIs,” she said. “Over a 25-week time period this unit had a zero CLABSI rate after they implemented the infection control nurse role within this unit.”

The initiative took place from July to December 2010. The SICU sustained a rate of zero for a 25-week period, eliminating 14 CLABSIs and saving several patient lives when compared to the same time period in the previous year, she reported. The average cost of a CLABSI is estimated to be \$18,432. By eliminating 14 CLABSIs, the team saved \$258,048, less \$44,000 for a nurse’s salary for six months, resulting in a net savings to the hospital of \$214,048.

“When you base that on an attributable mortality of about 20%, they essentially saved two to three lives,” Preas said. “We are just thrilled about it, though the unit is not completely at zero. They have had a few CLABSIs since that time frame, but this project has changed the culture in this particular unit. The nurses know that they are the ones that make the difference in terms of preventing infections. It is really

a business case [argument] for application of resources to prevent CLABSIs.” ■

## APIC CONFERENCE

### ‘Dignity’: IPs kick UTIs out of rehab

*Program leads to a 89% drop in infections*

UTIs have been termed the Rodney Dangerfield of infections, out of a skewed perception that they are easy to treat and have relatively little clinical consequence.

The conventional wisdom is that UTIs rarely lead to serious or fatal infections, but the Michigan Health & Hospital Association’s Keystone Center for Patient Safety & Quality estimates that 5% of all deaths caused by health care-associated (HAI) infections are from catheter-associated urinary tract infections (CAUTIs). That’s 5,000 fatal infections if one uses the typical ballpark figure of 100,000 HAI deaths annually.

The most common infectious complication of care, urinary tract infections are well worth preventing. It can be done, even in non-acute facilities that must adapt the guidelines created for other settings. Exhibit A is a 300-bed Nebraska rehabilitation hospital, where nurses, occupational and physical therapists, case managers and education staff collaborated with patients and their family members to dramatically reduce CAUTIs.

The interdisciplinary team at Madonna Rehabilitation Hospital in Lincoln, one of the largest free-standing rehabilitation hospitals in the country, reduced catheter associated urinary tract infections (CAUTIs) by 89% over a 14-month period, **Kristina Felix**, BA, RN, CRRN, CIC, an infection preventionist at the facility, reported recently in Baltimore at the annual educational conference of the Association for Professionals in Infection Control and Epidemiology.

Primarily, the team worked to decrease the use of catheters — a known risk factor for UTIs — discontinuing their use unless medically necessary. In cases where urinary catheters were required, the team educated nursing, therapy staff, family members and patients on proper care to reduce the chance of infection. When

the project was initiated in February 2010 the CAUTI prevalence rate was 36.6%, but dropped to a stunning 6.6% three months later. The original pilot concluded in April 2011.

Felix's team identified underlying reasons for catheter use when medical necessity was in question. Contributing factors included patients admitted to rehabilitation settings from acute care facilities with catheters in place, and patients whose families viewed catheters as a more convenient way to manage incontinence.

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### Adapting the guidelines

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"Our facility cares for patients with some very complex medical and physical needs," she says. "Best practice guidelines that are published really didn't [address] the problems that we see in our facility with bladder management and the needs of many of our patients. So we put together a task force. We wanted to understand first of all why the patient had the catheter, but more importantly what were the obstacles to removing them. We found that the use of the catheter sometimes was a 'convenience' for staff and actually for patients as well."

The task force improved bladder management protocols and standards, balancing the medical requirements of the patient with the need for patients to be infection-free, continually re-assessing the appropriateness for each catheter. They utilized a "de-catheterization protocol," to safely remove medically unnecessary catheters and improve the health of the patient.

"We looked at every facet of bladder management, including better ways to assist patients to the bathroom in a timely manner, different types of commodes and engaging the entire care team in the bladder management processes," she said. "We implemented education with all members of the care team, including patients and family members, so that everyone understood the process and the benefit to the patient of reduced UTIs."

Education regarding proper care of catheters and tubing was reinforced to staff and patients. Felix estimated that their program prevented up to 30 UTIs per month and saved the facility about \$1,000 per infection avoided. There were little additional costs associated with implementing these interventions. However, there was the rather difficult task of changing the perception of UTIs and catheters among staff

and even patients.

"It was quite an issue," she said. "At the beginning we asked a lot of questions of our therapists and nurses to see why we were using [catheters]. What was the thought process? People did think it was convenient, but we found that if the catheter was out — and it was a learning process — the patients were able to move about freer without the bag and tube — the patients actually felt better without it."

An aspect of patient "dignity" was restored in that regard, though again they had to change some perception among patients and family members that the catheter eases care.

"Overall, we have seen such a change in the thought process," she said. "We really don't like to use them and we are focused on getting them out when we can. If the patient does need the catheter, the focus is how we can prevent the infection. Everybody's mindset has changed. It helps to have the key administrative people [involved]. With that kind of support we couldn't do anything but move forward and be successful." ■

## OSHA targets outpatient areas for needle safety

*'They had absolutely no safety needles.'*

Outpatient care centers have historically attracted little attention from the Occupational Safety and Health Administration, although needle market data show they have lagged in sharps safety and been a recurrent source of hepatitis outbreaks among patients. The hands-off approach is ending in a four states, as a new regional emphasis program targets Alabama, Florida, Georgia and Mississippi.

OSHA inspectors will pay unannounced visits to ambulatory surgery, urgent care centers and medical clinics to gauge compliance with its Bloodborne Pathogen Standard. Those type of centers are not required to maintain OSHA 300 logs, so little is known about their sharps injury protection, says **Billy Kizer**, MPH, CSP, team leader for enforcement programs in OSHA's Region IV.

They also are not the focus of sharps safety surveillance efforts, which mostly have collected data from hospitals. Yet there is evidence that "alternate care" sites have much lower uptake of safety devices to protect health care work-

ers. In 2010, GHX, a health care supply chain management company based in Louisville, CO, reported that about one in five blood collection needles and blood collection sets in alternate sites were conventional devices, and about half (52%) of hypodermic needles were not safety-engineered.

The special emphasis program "is a great way to determine how many sharps injuries they're really having [in alternate sites] as well as making sure they're following the Bloodborne Pathogen Standard and they're providing the protection for sharps," says Kizer. "It's time that we reach out and ensure they are protecting their employees."

The attention from OSHA will send a message that outpatient centers need to get into compliance, says **Bruce Cunha**, RN, MS, COHN-S, manager of employee health and safety at the Marshfield (WI) Clinic and a surveyor for the American Association for Accreditation of Ambulatory Surgery Facilities.

Cunha was surprised to find facilities that had essentially ignored the Bloodborne Pathogens Standard. "I went in the ORs and they had absolutely no safety needles," he says.

Surgeon or physician preference alone is not a sufficient reason to use conventional needles, says Cunha. The facilities must provide documentation of an exemption from sharps safety for medical reasons, he says.

OSHA's random inspections will include free-standing facilities that are owned by hospitals. However, it will not include physicians' offices, Kizer says. The regional special emphasis program will run through Sept. 30, 2012, and involves states that are under federal OSHA jurisdiction. State-plan states in the region, including Tennessee, Kentucky, North Carolina and South Carolina, may do a similar program but are not required to do so.

OSHA inspectors rarely go into outpatient centers unless there is a complaint from an employee, Kizer notes. But outpatient centers have been the focus of a different national awareness program to improve injection safety. The One & Only Campaign of the Centers for Disease Control and Prevention and the Safe Injection Practices Coalition is emphasizing the importance of using a needle and syringe only one time. Reuse of needles or syringes with multi-dose vials has led to the transmission of hepatitis C from patient to patient.

The OSHA program extends that safe injec-

tion message to worker safety. "Our hope is that we'll find that employers are doing what they're supposed to do, that employees are being protected," says Kizer. "If they're not, we can help to bring them into compliance." ■

## SHEA updates scope reprocessing guidelines

### *Infections rare, outbreaks a concern*

The Society for Healthcare Epidemiology of America (SHEA) and the American Society for Gastrointestinal Endoscopy (ASGE) have updated their 2003 joint guideline for reprocessing gastrointestinal endoscopes to reaffirm reprocessing methods and take into account evolved technology and disinfection systems.

The initial guideline, published in 2003, was drafted in collaboration with multiple physician and nursing organizations, infection prevention and control organizations, federal and state agencies, and industry leaders to develop evidence-based guidelines for reprocessing gastrointestinal (GI) endoscopes. ASGE, SHEA and nine other collaborating organizations have updated the previous guideline with additional discussion of new or evolving reprocessing issues and updated literature citations.

"These guidelines ensure that all clinicians are following the most up to date evidence-based methods to help keep patients safe," says **Keith Woeltje**, MD, PhD, chair of SHEA's Guidelines Committee. "The rare occurrence of transmission via endoscope speaks to the efficacy of reprocessing methods and shows the impact this guidance has in practice."

To date, all published occurrences of pathogen transmission related to GI endoscopy have been associated with failure to follow established cleaning and disinfection/sterilization guidelines or use of defective equipment. Despite strong data regarding the safety of endoscope reprocessing, clinicians' concerns about the potential for pathogen transmission during endoscopy have raised questions about the best methods for disinfection or sterilization of these devices between patient uses. Since the 2003 guideline, high-level disinfectants, automated reprocessing machines, endoscopes and endoscopic accessories have all evolved; however, the efficacy of decontamination and

*continued on p. 84*

## CNE/CME Questions

1. The Centers for Medicare and Medicaid Services is creating an infection control inspection survey for hospitals as part of its participation in what recently formed collaborative that includes hospitals, caregivers, patient advocates, and government agencies?  
A. Partnership for Patients  
B. Stop Hospital Infections  
C. Clean Hands Together  
D. Center for Quality Transformation
2. Infection preventionists at Trinity Medical Center in the Quad Cities on the Iowa/Illinois border used red duct tape as an innovative addition to their patient isolation rooms. What did they create?  
A. a hand hygiene corridor at the patient bedside  
B. a clearly designated area for visitors  
C. a three-foot square safe zone by the door  
D. bright frames around alcohol hand hygiene dispensers
3. How much were catheter-associated urinary tract infections (CAUTIs) reduced by a multifaceted prevention effort at Madonna Rehabilitation Hospital in Lincoln, NE?  
A. 17%  
B. 31%  
C. 68%  
D. 89%
4. The Occupational Safety and Health Administration will conduct announced inspections of ambulatory care centers to assess compliance with its bloodborne pathogen standard as part of a regional emphasis program in which of the following states?  
A. California, Oregon, Nevada and Washington  
B. Alabama, Florida, Georgia and Mississippi  
C. Arkansas, Kansas, Oklahoma and Missouri  
D. New Hampshire, New York, Maine and Vermont

## CNE/CME Instructions

To earn credit for this activity, please follow these instructions.

1. Read and study the activity, using the provided references for further research.
2. Log on to [www.cmecity.com](http://www.cmecity.com) to take a post-test; tests can be taken after each issue or collectively at the end of the semester. *First-time users will have to register on the site using the 8-digit subscriber number printed on their mailing label, invoice or renewal notice.*
3. Pass the online tests with a score of 100%; you will be allowed to answer the questions as many times as needed to achieve a score of 100%.
4. After successfully completing the last test of the semester, your browser will be automatically directed to the activity evaluation form, which you will submit online.
5. Once the completed evaluation is received, a credit letter will be e-mailed to you instantly. ■

## CNE/CME Objectives

- Upon completion of this educational activity, participants should be able to:
- Identify the clinical, legal, or educational issues encountered by infection preventionists and epidemiologists;
  - Describe the effect of infection control and prevention issues on nurses, hospitals, or the health care industry in general;
  - Cite solutions to the problems encountered by infection preventionists based on guidelines from the relevant regulatory authorities, and/or independent recommendations from clinicians at individual institutions. ■

## COMING IN FUTURE MONTHS

■ Complete coverage of APIC from Baltimore

■ Will CA reporting law go nationwide?

■ First look at the new CMS inspection tool

■ OSHA's dogged pursuit of an ID standard

■ How will Joint Commission and CMS work together in surveys?

continued from p. 82

high-level disinfection is unchanged and the principles guiding both remain valid.

Despite the large number and variety of GI endoscopic procedures performed, documented instances of infectious complications remain rare, with an estimated frequency of 1 in 1.8 million procedures, says **Bret Petersen, MD, FASGE**, chairman, of the ASGE Quality Assurance in Endoscopy Committee.

"Since the 2003 guideline was published, additional outbreaks of infection related to suboptimal infection prevention practices during endoscopy or lapses in endoscope reprocessing have been well publicized," he adds. "Given the ongoing, but rare, occurrences of endoscopy associated infections attributed to lapses in infection prevention, an update of the multisociety guideline was warranted."

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### ***Complete cleaning first***

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Flexible GI endoscopes should first be completely cleaned and then subjected to at least high-level disinfection -- a recommendation by a wide variety of groups for years. The specific additions or changes published in the SHEA and ASGE "Multisociety guideline on reprocessing flexible gastrointestinal endoscopes: 2011" include:

- Review of expanded details related to critical reprocessing steps (including cleaning and drying)
- Review of reprocessing issues for various endoscope attachments such as flushing catheters
- Distinction between risks related to endoscope reprocessing and those related to peri-procedural practices, including medication administration
- Discussion of related issues for which data are absent or insufficient to guide practice, including:
  - Endoscope shelf life or "hang time" (the interval of storage after which endoscopes should be reprocessed before use)
  - The role of microbiological surveillance testing of endoscopes after reprocessing
  - Questions regarding endoscope durability and longevity from the standpoint of infection prevention.

For more information go to: <http://bit.ly/jWdJd> ■

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