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ID groups urge CMS to mandate antimicrobial stewardship programs

Patient's choice: Amputate leg or a lifetime of dialysis?

The harsh reality of losing antibiotics

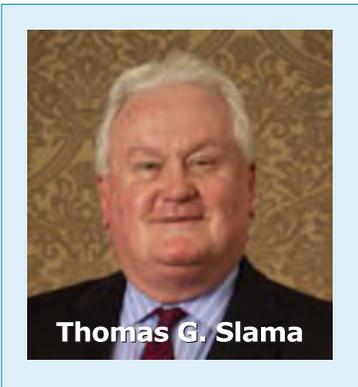
Infectious disease societies frustrated at watching antimicrobial resistance increase for decades are taking the unusual step of asking for federal regulation and oversight of clinical practice, imploring the Centers for Medicare & Medicaid Services (CMS) to require hospitals to implement antimicrobial stewardship programs.

While multidrug-resistant strains of a formidable array of bacteria have developed over the past 30 years, there has been a dramatic drop in the development of new antibiotics, warns a policy statement on antibacterial stewardship by the Society for Healthcare Epidemiology of America (SHEA), the Infectious Diseases Society of America (IDSA), and the Pediatric Infectious Diseases Society.¹ The critical need for infection control goes without saying, but the call for mandatory stewardship to reign in the widespread unnecessary use of antibiotics is

roughly equivalent to the first rule of holes: When finding yourself in one, stop digging.

"Our position is that clearly unless hospitals are forced to participate in antimicrobial stewardship and the government is forced to support new antibiotic drug development, then we will only be in a worse hole and a world of hurt," says **Thomas G. Slama**, MD, FIDSA, president of IDSA, and clinical professor

of medicine at the Indiana University School of Medicine in Indianapolis.



Thomas G. Slama

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Indeed, the world is dangerously close to the initial phases of a "post-antibiotic era," where drug resistant pathogens cause infections that cannot be treated. Antimicrobial stewardship is one of the best ways to head off the crisis, as overused and misused drugs select out resistant organisms and perpetuate the cycle.

In seeking CMS regulatory action, the position paper called for the required creation of a multidisciplinary antimicrobial stewardship team that is physician directed or supervised and includes a physician, a pharmacist, a clinical microbiologist, and an infection preventionist. "SHEA, IDSA, and PIDS recommend that the CMS require participating healthcare institutions to develop and implement antimicrobial stewardship programs," the paper states. "This can be achieved by incorporating the requirement into existing regulations via expansion of interpretive guidelines of the relevant regulation(s)."

Such regulations should not be limited to hospitals, they noted, arguing that stewardship should be required in long-term care facilities, ambulatory surgical centers, dialysis centers and other health care settings.

Informal conversations with CMS while working on the stewardship policy statement indicate support for the idea of regulating at



Neil Fishman, MD

the agency, says **Neil Fishman, MD**, a chief architect of the policy statement and chair of the board of directors for the SHEA Education and Research Foundation in Arlington, VA. As previously reported, the CMS does include some

assessment of antibiotic stewardship as part of its new infection control inspections slated for later this year, but there is currently no regulation requiring such policies.

"CMS circulated a new draft of their interpretative guidelines for CMS surveys, and the draft does contain some questions related to antimicrobial stewardship issues, but these are not scored and there's no penalty for not addressing antimicrobial stewardship," Fishman says. "It's a way to start collecting more data."

However, the ID groups' request could fall on sympathetic ears, given the unprecedented interest CMS has taken in infection prevention in the last few years. Increasing

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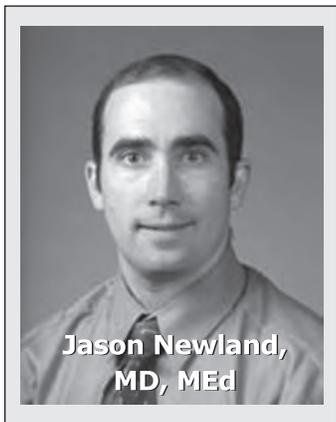
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accounts of persistent or outright untreatable infections will certainly add political pressure for action.

'My father never saw a patient die of drug resistance'



Jason Newland,
MD, MEd

"What we are getting closer to is what it was like before antibiotics," says **Jason G. Newland, MD, MEd**, director of the antibiotic stewardship program and associate professor of pediatrics at the University of Missouri-Kansas City

(MO) School of Medicine, Children's Mercy Hospitals & Clinics.

A second-generation doctor, Newland says his father never saw such cases in his practice 30 years ago. "My father never saw a patient die of drug resistance, but that is happening more and more now," he says. "We had a child come into the hospital with a urinary infection that took 10 days to treat intravenously, and other pediatricians could tell you worse stories than that."

Citing recent reports that about half of *Klebsiella pneumoniae* isolates are now resistant to carbapenems, Newland says, "essentially what that means is a person can go to the hospital, but if he has one of those infections there's only one other drug [colistin] that you can use to treat it. And the only people who really know about this problem are the infectious disease people."

As we have previously reported, colistin, a powerful antibiotic which can contribute to kidney problems, is an undesirable last-line choice for some of the rapidly emerging gram negative infections. (See *Hospital Infection Control & Prevention Jan. 2011, p. 1.*)

And undesirable choices are not limited to drugs. Consider a recent case described by Fishman, past-president of SHEA and associate chief medical officer at the University of Pennsylvania Health System in Philadelphia, PA.

"Recently, we had a patient sent here from another hospital. A 54-year-old man had an infection caused by bacteria that was sensitive to only one antibiotic, and this single antibiotic was causing renal failure in the patient," Fishman says. "This man had fallen off a roof and injured his leg. He had a lot of surgery on it, and when it became infected, ultimately all we could offer him was treatment with an antibiotic that would result in him receiving dialysis the rest of his life with no guarantee the antibiotic would work, or he could have his leg amputated. He chose amputation. It amazes me that those are the types of decisions we're faced with in 2012."

ID Groups to CMS: Act now

"A requirement of having an antimicrobial stewardship program is one of the best opportunities to limit resistance," Newland says. It's imperative that the U.S. government does not wait until a full-blown crisis emerges, as has happened in Greece, where overprescribing and lax infection control processes have contributed to something of an antimicrobial nightmare.

"How do we avoid that problem? Everyone knows if you don't use antibiotics you don't get resistance," Newland says. "We need to use antibiotics only when they need to be used."

That is, of course, not what is happening, as roughly half of all antibiotic administration is thought to be unnecessary.

The chief roadblock to new antibiotic development is financial. "The minimum it costs to develop an antibiotic is \$1 billion dollars," Slama says. "And 96% of compounds developed chemically never make it to the marketplace, so the odds of pouring all of this money into a project and coming up with a successful product is very much against the producer."

As noted, antibiotics remain more potent if they are used less, which means there will be pressure on physicians not to prescribe a new drug unless it is absolutely necessary. That makes antibiotics a far less appealing marketing option to pharmaceutical companies than are treatments for chronic illnesses.

"If you couple these obstacles with

Continued on p. 53.

What would a CMS antibiotic reg require?

ID groups: Antibiograms, clear clinical need

A policy statement by the Society for Healthcare Epidemiology of America (SHEA), the Infectious Diseases Society of America (IDSA), and the Pediatric Infectious Diseases Society includes a recommendation that "antibacterial stewardship programs should be required through regulatory mechanisms."¹

The infectious disease groups made the following key points in making this unusual request for regulatory intervention into clinical practice:

At present there are no national or coordinated legislative or regulatory mandates designed to optimize the use of antimicrobial therapy through antimicrobial stewardship. Legislation is also limited at the state level. California Senate Bill 739 mandated that by January 1, 2008, the California Department of Public Health (CDPH) require that all general acute care hospitals develop a process for evaluating the judicious use of antibiotics, the results of which shall be monitored jointly by appropriate representatives and committees involved in quality improvement activities. While this is the first legislative mandate of its kind, it does not specify that hospitals must intervene to improve antimicrobial use, that is, to have an antimicrobial stewardship program. Thus, the CDPH is learning that given the nonspecific wording used in the mandate, many hospitals are able to meet this requirement without having an antimicrobial stewardship program that meets the objectives as defined above. On the other hand, successful antimicrobial stewardship programs in California are varied, utilizing different combinations of staff, strategies, and criteria; therefore, changing the regulation to be too specific may prevent resource-limited hospitals from developing robust antimicrobial stewardship programs on the basis of facility-specific attributes.

In a preliminary assessment of acute care hospitals in California, 23% of hospitals reported being influenced to start an antimicrobial stewardship program because of Senate Bill 739. Lessons learned from statutory requirements in California include that regulatory mandates are important in convincing hospital administration to fund and staff antimicrobial stewardship programs. It is important to use the wording "antimicrobial stewardship program" in the regulation, as defined above, but it is also important to allow hospitals the flexibility to define how their facility can best meet the objectives of an antimicrobial stewardship program. Inasmuch as current legislation is limited to

a single state and focuses only on institutional evaluation of antimicrobial use in hospitals, we support broad implementation of comprehensive antimicrobial stewardship programs across all healthcare settings.

SHEA, IDSA, and PIDS recommend that the Centers for Medicare and Medicaid Services (CMS) require participating healthcare institutions to develop and implement antimicrobial stewardship programs. This can be achieved by incorporating the requirement into existing regulations via expansion of interpretive guidelines of the relevant regulation(s). Minimum requirements for the program should include:

A. Creation of a multidisciplinary interprofessional antimicrobial stewardship team that is physician directed or supervised. At a minimum, 1 or more members of the team should have training in antimicrobial stewardship. The number of team members may vary on the basis of the size and complexity of the facility. Team members should include but are not limited to: A physician, a pharmacist, a clinical microbiologist, an infection preventionist.

B. A formulary limited to non-duplicative antibiotics with demonstrated clinical need.

C. Institutional guidelines for the management of common infection syndromes.

D. Additional interventions to improve the use of antimicrobials, including those designed to detect and eliminate:

- Multidrug regimens with unnecessarily redundant antimicrobial spectra.
- Antibiotic therapy for the management of nonbacterial syndromes or cultures that represent contamination or routine colonization.
- Empiric regimens that are either inadequately or excessively broad spectrum for infection syndromes.
- Regimens that do not adequately treat infections caused by culture-confirmed pathogens.

E. Processes to measure and monitor antimicrobial use at the institutional level for internal benchmarking.

F. Periodic distribution of a facility-specific antibiogram indicating the rates of relevant antibiotic susceptibilities to key pathogens.

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Continued from p. 51.

the bureaucracy and hurdles that have to be crossed with the Food and Drug Administration or working with other government agencies, then you have a process that is long, complicated, bureaucratic, and expensive," Slama explains. "It's a no-win situation."

Still, new antibiotics are greatly needed, so either the federal government or nonprofit organizations will need to help out with the cost of developing them, he adds.

In the interim, the best solutions remain stringent infection control measures and antimicrobial stewardship. Studies show that antimicrobial stewardship decreases the cost of health care, which is another reason to implement such programs, Fishman says.

"I am challenged to think of any other interventions that improve the quality and safety of healthcare and decrease the cost of health care," he adds.

While cost should make stewardship more attractive to health systems, it should not be the driving force behind implementing antimicrobial stewardship programs, says **Sara Cosgrove**, MD, MS, an associate professor of medicine in the division of infectious diseases at Johns



Sara Cosgrove,
MD, MS

Hopkins University School of Medicine in Baltimore, MD. Cosgrove is on SHEA's board of directors and has conducted a recent study on antimicrobial stewardship. (See *antimicrobial stewardship study*, p. 55.)

If health systems make cost savings a main tenant of their stewardship programs then it will be unsustainable, Cosgrove says.

"You initially will have a cost savings, but these cannot be sustained because if you pick the cheapest drug it would be fluoroquinolones, and we do not want everyone on those drugs," she says. "Patient safety should be the chief goal."

Antimicrobial stewardship has parallels to infection control programs, which have been

accepted for decades, but once were rare.

"In the 1950s, no one had infection control programs, then there were more issues and concerns, and CMS said we have to make infection control a condition of participation and accreditation surveys look at it," Cosgrove explains. "Infection control programs are funded because the national patient safety goals say they have to do this."

REFERENCE

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Changing the antibiotic mindset of docs, patients

Education, better use data, research

In addition to calling for federal regulation requiring antimicrobial stewardship, a position paper by leading infectious disease groups recommended several other measures to preserve remaining antibiotic efficacy.

Monitor antimicrobial stewardship in ambulatory healthcare settings.

More ID doctors, pharmacists, and other clinicians are needed to monitor and oversee ambulatory settings' antimicrobial stewardship programs. Also, these settings should integrate clinical decision support technology into electronic health records and into e-prescribing mechanisms, the position paper states.

"All of these changes, listed in the position paper, are necessary for the evolution of care in and out of a hospital setting that involves antibiotics and infectious diseases," says **Thomas G. Slama**, MD, FIDSA, president, IDSA, and clinical professor of medicine at the Indiana University School of Medicine in Indianapolis, IN.

The involvement of ID physicians and clinicians trained in infectious diseases is crucial to these programs' success, he says.

Just like heart disease patients see a cardiologist for their care, patients with high-risk infectious diseases need to see an ID expert, he

adds.

Educate clinicians and the public about antimicrobial resistance and antimicrobial stewardship.

Education is lacking for patients and medical trainees on this critical issue, emphasizes **Jason G. Newland**, MD, MEd, director of the antibiotic stewardship program and associate professor of pediatrics at the University of Missouri-Kansas City (MO) School of Medicine, Children's Mercy Hospitals & Clinics.

"We don't teach families and society how to use these drugs," he says. "I've had people come to me and say, 'I need a z-pack.' They know they usually go to the physician's office and get a drug they think will make them feel better."

What physicians need to do is tell patients: "You don't need this. I know you are coughing up green stuff, but you're going to be fine."

But doctors infrequently do not do this because they know that if a patient wants an antibiotic from them and does not get it, the patient might go to another doctor who will make the prescription, Newland says.

"What we need to do is educate families and patients, saying, 'This is why we're not going to use these drugs.'"

Norwegian countries have done a good job of making antibiotics a less-prescribed and requested drug, he notes.

"The resistance rates are super low," Newland says. "What I've been told is the families will go to a doctor and if the doctor gives them an antibiotic they see it as a negative thing."

Patient education materials about antibiotics are available on the Centers for Disease Control and Prevention "Get Smart" website including brochures and pamphlets for hand out. (<http://1.usa.gov/JnHc2t>)

"Up until now the Get Smart program focused on pediatric populations, but they are expanding it to address the issue of antibiotic use in the adult population, as well," says **Neil Fishman**, MD, associate chief medical officer at the University of Pennsylvania Health System in Philadelphia, PA.

"The campaign addresses the use of antibiotics for bronchitis, the common cold, and sinusitis, which all are diseases most often caused by viruses, so antibiotics are not effective in treatment."

In addition, clinician education on antimicrobial stewardship should be reinforced during internships and residencies.

"Outpatient medicine is a dilution of inpatient medicine, and most doctors do what they saw or were taught as trainees," Slama says. "So if you change the process in the hospital, then the doctors will change their practices when they go into the community."

When health systems first begin clinician education about antimicrobial stewardship, they might use guidelines and formularies, spot auditing of antibiotic use, individual clinician teaching, and grand round teaching at the bedside with infectious disease physicians, he suggests.

"We need to have a formal curriculum during the time they're seeing patients," Newland adds. "Antimicrobial stewardship needs to be brought into the fabric of those settings, which is the best time for learning."

Collect antimicrobial use data and make it readily available for inpatient and outpatient settings.

The United States is lacking readily available data for tracking and benchmarking antimicrobial use, and such data are critical to antimicrobial monitoring, the position paper says.

Also, antimicrobial use data can be used as part of an incentive-based payment system.

While antibiograms tell part of the story, more data are needed to give clinicians and health systems a complete picture of antimicrobial resistance in their hospitals and communities, Newland says.

"We also need to set up standards and to do this we have to improve decisions about what appropriate use is," he adds. "Antimicrobial stewardship is a 20-year-old field, and it's just now that people are beginning to recognize it because of resistance problems."

Increase research on antimicrobial stewardship.

"Most physicians and health care providers understand that resistance is a growing problem," Fishman says. "But it's difficult to think beyond the single patient they're taking care of."

Antimicrobials are different from other drugs prescribed because they have an ecological impact, he adds.

"Antimicrobials are the only drugs where use

in one individual can impact the ability to use the drug in another individual," Fishman says.

Research into how antimicrobial stewardship affects the ecological impact is needed.

"To date there has been only a single multicenter study that looked at the impact of antimicrobial stewardship, and it was just published," Fishman says. (See story, this page.) "Most research has focused on specific types of interventions during outbreaks of infections with resistant organisms and these were only in single institutions or single units of individual hospitals."

Research in antimicrobial stewardship today is where infection control research was 15-20 years ago, he adds.

"There's a lot of work that needs to be done," he says. "The big problem is there's not an obvious or ready funding source for this research, and the National Institutes of Health has not put out grants for this type of research that we're calling for."

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1. Policy Statement on Antimicrobial Stewardship by the Society for Healthcare Epidemiology of America (SHEA), the Infectious Diseases Society of America (IDSA), and the Pediatric Infectious Diseases Society (PIDS) *Infect Cont Hosp Epi*, Vol. 33, No. 4, Special Topic Issue: Antimicrobial Stewardship (April 2012), pp. 322-327 ■

Post-script review, feedback curtails antibiotic use

Physician buy-in is the key

A new multicenter study shows that antimicrobial stewardship expressed as a post-prescription review and feedback intervention can decrease antimicrobial use, especially when it's part of an established antimicrobial program.¹

This was the first study to look at performing the same antimicrobial stewardship intervention at multiple academic hospitals, says **Sara Cosgrove**, MD, MS, an associate professor of medicine in the division of infectious diseases at Johns Hopkins University School of Medicine in Baltimore, MD.

"We took five different academic medical centers and came up with standardized data collection materials and interventions," Cosgrove explains. "The intervention was that

at 48-72 hours we had an infectious disease physician review the use of broad spectrum antibiotic use on some medical and surgical floors of the hospital."

If the ID physician did not believe broad spectrum antibiotics was appropriate, the doctor would call the medical teams to recommend stopping the antibiotic.

The study's end point was to see if antibiotic use changed from the baseline, before calls were made, to the time after the intervention occurred.

"There was a mixed benefit," Cosgrove says.

"In hospitals where there was an established antimicrobial program that included salary support and intellectual support of stewardship, there was a decrease in antimicrobial use in the follow-up period," she says. "In other hospitals, where programs had just started or did not exist, we didn't see any reduction in antibiotic use."

The study's findings suggest that health systems that have a comprehensive antimicrobial stewardship program in place with financial and moral support from the institution have clinicians who are more likely to accept the recommendations of an infectious disease doctor.

"This lends support to the notion that hospitals should support and endorse stewardship programs, and there needs to be some kind of organized approach," Cosgrove says. "If it were mandated and everyone did it, then it would be even easier to convince physicians to make changes because it would be normal."

When investigators looked closely at prescribers' actions, they found that they were much more likely to take a recommendation to change the patient's antimicrobial than they were to stop the antibiotic, she notes.

"There might be some nervousness about stopping antibiotics with doctors thinking there might be an infection that has not been discovered," she explains. "In stewardship, you'd much rather have them stop the drug if it's not indicated, and stopping antibiotics is how we'll improve resistance."

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Finding low-hanging fruit in antimicrobial stewardship

Many IV fluoroquinolones unnecessary

Researchers are finding a systemic problem involving the unnecessary use of IV fluoroquinolones in the acute care wards of hospitals. While the data came from 128 Veterans Administration (VA) hospitals, the research suggests this is a trend that all health care systems should address through antimicrobial stewardship programs.¹



Makoto Jones, MD

“For antibiotic stewardship, we wanted to pick a topic where we could get a sense of how things were going in the VA and probably elsewhere, as well,” says **Makoto Jones**, MD, research investigator and staff physician at the VA Salt Lake City Health Care System in Salt

Lake City, UT.

Parenteral to oral conversion of fluoroquinolones is a relatively easy stewardship step to take, he notes.

“It may be a marker of how well an antibiotic stewardship program is doing,” Jones adds.

The 152-bed VA hospital system uses a barcode medication administration to make sure that the right patient gets the right medication. The VA electronic health record collects these and other data, including admission/discharge/transfer data, which tells where a patient is at any given time in the hospital.

“We were able to look at whether an antibiotic was given intravenously or by mouth,” Jones says. “We set up the rules so if somebody was given IV antibiotics for two days in a row, we took that as their intention to give IV antibiotics.”

Barcode medication administration data were used because medication orders often can change within the first day — sometimes even before a single dose is administered, he explains.

Researchers focused on fluoroquinolones

because the drug’s bioavailability is the same whether it’s given intravenously or orally. So if the patient’s gastrointestinal tract could handle the oral medication then many patients could be switched from IV to oral antibiotics, he adds.

“It’s an easy switch, and we have randomized control trials saying it appears to get people out the door faster and in a safe manner,” Jones says. “If we continue to give patients IV antibiotics they probably stay in the hospital longer than they need to.”

Providers sometimes have a mental block about the IV to PO conversion if patients are not transitioned early in their hospital stay.

“Providers think they have to go through a certain process to get the patient out the door,” Jones explains. “Most of these patients are pneumonia patients, and the difference in length of stay is on the order of five days. A previous VA study in the 1990’s demonstrated a six-day length of stay for those experiencing early IV to PO conversion versus an 11-day length of stay for those that continued to receive IV therapy.”

Almost half of IV use avoidable

The research question was framed this way: What is the proportion of IV fluoroquinolone days out of all fluoroquinolone days that is unnecessary and potentially avoidable, and what is the proportion of IV fluoroquinolone days out of all IV fluoroquinolone days that is potentially avoidable IV fluoroquinolone use?

Investigators found that avoidable IV fluoroquinolone use overall was 46.8% of all fluoroquinolone days. The percentage of IV fluoroquinolone days that was avoidable was 90.9%.¹

“The idea here is that of all the fluoroquinolones you are using, close to half are IV when they could have been PO,” Jones says.

“This is the low-hanging fruit aspect,” he adds. “We felt this switch was one of the more simple things to implement for antibiotic stewardship programs.”

Infectious disease physicians already know that the IV to PO conversion in antibiotics can save in drug costs and administrative costs, as well as preventing unnecessary patient hospitalization, Jones says.

“We focused on this because in all the rural, small hospitals, the question is where do you

start in antibiotic stewardship, and we're presenting evidence that you start with the basics and then continuously monitor it," he says. "When you begin with the basics, the more difficult things like quantifying and measuring de-escalation can be the next step."

The research also addresses the limitations of the study by providing alternative measures without counting patients' first two days of IV fluoroquinolone administration or any IV fluoroquinolone use in the ICU. Taking out these components resulted in the statistics being cut in half: 20.9% of IV fluoroquinolone days out of all fluoroquinolone days were avoidable, and 45.9% of IV fluoroquinolone days out of all IV fluoroquinolone days were avoidable.¹

"This study doesn't really add to the science of IV to PO conversion, but as far as systematic measurement and comparisons go, it shows the magnitude of what can be done," Jones says.

"People have been harping on this for 10 to 15 years, and the study indicates there is room for quality improvement," he adds. "And we did find some correlation between avoidable fluoroquinolone use and all antibiotic use, indicating there may be underlying, hidden influences of overall hospital antibiotic stewardship quality."

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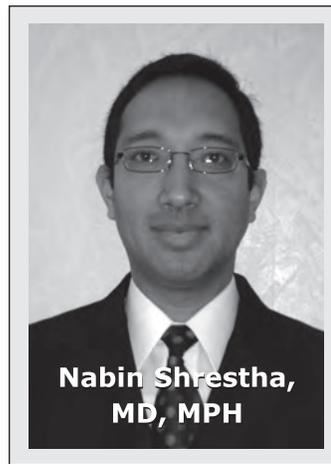
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Does the patient need IV drugs at discharge?

Many times the answer is no

Investigators — evaluating more than 240 patients over a three-month period — found that infectious diseases (ID) physicians correctly identified patients who did not need to be discharged on community-based parenteral anti-infective therapy (CoPAT).¹

"Whenever someone leaves the hospital on intravenous (IV) antibiotics in our institution, their case has to be evaluated by an ID physician," says **Nabin K. Shrestha**, MD, MPH, staff physician in the department of infec-



**Nabin Shrestha,
MD, MPH**

tious disease at the Cleveland Clinic in Cleveland, OH.

"For some patients we will decide to stop the IV antibiotic, and the question was whether we are causing harm by doing that," he explains. "So we compared emergency department and hospital read-

missions within 30 days for these patients."

Researchers found that ID physicians stopped IV antibiotics in 29% of patients, sometimes replacing them with oral medication, and in other cases stopping antibiotics altogether. Of the 69 patients for whom IV antibiotics were stopped, none were readmitted for infection within the 30-day time period, he says.

"Out of the 69 patients 27 did come back to the emergency department, but they returned for other illnesses, like congestive heart failure, and not for infections," Shrestha says. "We felt that was very positive, and we were very happy with what we found."

In most hospitals an ID physician evaluation is not necessary before discharging patients on IV antibiotics. This represents a lost opportunity for antimicrobial stewardship at a time of care transition out of the hospital, and probably results in a large proportion of patients being discharged with antibiotics when they don't need them, Shrestha notes.

Even hospitals that have antimicrobial stewardship programs usually limit their stewardship of antibiotic use to hospitalized patients and do not have mechanisms in place to control antibiotic use at points of care transition, he adds.

"In our institution we've built up a culture where they're evaluated by infectious disease physicians," he says. "It takes a lot of commitment to do it that way."

Cleveland Clinic physicians will request an ID physician consultation for the purpose of managing a patient's post-discharge antibiotics while the patient is still hospitalized.

"The doctors think the patient needs antibiotics, and they have to call the infectious disease physician to make that happen," Shrestha says.

"We screen the patient and are fully involved in the care, deciding whether the patient needs antibiotics and whether it should be IV or oral antibiotics."

When ID physicians evaluate patients at discharge, they look for evidence of infection and other associated medical and social factors to help decide if antibiotics are necessary, and, if so, which antibiotics are most appropriate.

"Sometimes you agree there's an infection and it needs to be treated," Shrestha says. "We speak with the patient, look through the records, and we take responsibility for that patient."

They also make follow-up arrangements for the patient, including a visit to see the ID physician in the ID clinic when it's appropriate. About 86% of patients had a follow-up appointment with an ID physician, he says.

Several health care systems have contacted Shrestha to discuss the study and the Cleveland Clinic's antimicrobial stewardship program, and others are considering instituting a program like this. But it takes time and resources.

Having an ID physician consultation is a model that would be feasible in larger health care institutions. But all hospitals could follow some of the same antimicrobial stewardship practices, including stopping antibiotic use at discharge when there is no clinical evidence the patient has an ongoing infection, Shrestha says.

Controlling antimicrobial prescribing reduces antimicrobial resistance and *Clostridium difficile* infections and they save health systems money. Expanding these practices to the discharge process will increase the benefits, the study says. The key would be to target higher risk antimicrobial treatment plans.

"I think we have significant challenges today because of a lack of antibiotics for some serious infections," Shrestha says. "We're seeing very few new antibiotics being developed, and the ones we have are developing resistance increasingly, and there are some strains of bacteria where doctors have difficulty finding any antibiotic that works."

These problems make antimicrobial stewardship an increasingly attractive step toward reducing resistance.

"Different institutions have different constraints, so we can't specify exactly what they

need to do, but every institution should think about antimicrobial stewardship and do something about it," Shrestha says.

REFERENCE

1. Shrestha NK, Bhaskaran A, Scalera NM, et al. Antimicrobial stewardship at transition of care from hospital to community. *Infect Cont Hosp Epi* 2012; 33(4):401-404. ■

Norovirus outbreaks trigger unit closures

Organism tops list of outbreaks

Norovirus is the organism most likely to trigger a shutdown of units in your hospital. And according to a recent survey of infection preventionists, it is responsible for more outbreaks than some deadlier organisms, such as *Clostridium difficile* and *Staphylococcus aureus*.¹

It poses a risk to patients and employees alike. "Norovirus is different from the other [health-care acquired] organisms because norovirus can affect employees, and in outbreaks many times does," says lead author **Emily Rhinehart**, RN, MPH, CIC, vice president and division manager of the health care division of Chartis Global Loss Prevention in Atlanta.

In fact, norovirus outbreaks were as likely to occur in behavioral health and rehabilitation units as medical/surgical units, another contrast to other organisms. In those units, patients are more mobile, and therefore more likely to contract or transmit the disease, Rhinehart notes. "They're walking around their environment and interacting with the environment and other patients and the employees are interacting with them," she says.

Last year, the Centers for Disease Control and Prevention issued an updated guideline on norovirus in health care settings, and the agency released a toolkit to help hospitals and other facilities cope with outbreaks.

Norovirus outbreaks are easy to identify because they are often dramatic, with sudden onset of nausea, vomiting and diarrhea. Norovirus "has a very short incubation time, it's very transmissible, and a lot of people can be infected in a short amount of time," says **Clifford McDonald**, MD, medical epidemiologist at CDC.

The virus is not associated with significant mor-

tality. An unpublished analysis of death certificates found that *C difficile* was associated with about 14,000 deaths in a year compared with just 800 for norovirus, McDonald says.

Still, it presents significant challenges for both infection control and employee health professionals. Here are some issues to keep in mind:

● **Monitor employee absences.** If you see a pattern of digestive illness among employees, particularly in the same unit, that may be a clue about an outbreak. Being alert can help you detect norovirus and implement strategies to prevent its spread, says Rhinehart.

● **Don't penalize employees for being sick.** You want ill employees to stay home if they're sick — and during an outbreak, you might require some exposed employees to stay home for a two- or three-day incubation period. Make sure your policies don't penalize them for reporting symptoms or an exposure by requiring them to take time from a pool of paid time off. Some employers have used workers' compensation or even a contingency fund to cover those payments for ill or exposed employees to stay home, Rhinehart says.

● **Emphasize glove use and hand hygiene.** Alcohol gel may not be as effective against norovirus as hand-washing. But while you can educate staff and encourage hand-washing, don't try to completely revamp your hand hygiene program, says McDonald. Alcohol gel has been extremely effective in combating other organisms, and studies show it improves compliance with hand hygiene, notes McDonald.

You should emphasize glove use and changing gloves between patients, he says. "Glove use is only as good as your practice of changing gloves between patients," he says. "If you don't change them between patients, you're doing nothing for patient safety." It is also important for employees to remove the gloves in a way that prevents contamination of their hands and to perform hand hygiene after removal.

Report outbreaks to the state health department. While hospitals had surveillance

programs to detect health care acquired infections, the survey of infection preventionists found that only 52% of the outbreaks had been reported to an external agency, such as the local or state health department. Some hospitals might be reluctant to bring attention to their outbreak, or they might feel they don't need the help of public health authorities, says McDonald. Yet reporting allows for a greater awareness of the disease spread and may even warn nearby hospitals of a circulating organism, he says.

REFERENCE

1. Rhinehart E, Walker S, Murphy D, et al. Frequency of outbreak investigations in US hospitals: Results of a national survey of infection preventionists. *AJIC* 2012; 40:2-8. ■

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 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%.
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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

■ APIC takes on Texas, full coverage from San Antonio

■ Tips and strategies to comply with CMS inspection program

■ Hepatitis C testing in dialysis: A sin of omission?

■ Improving collaboration with the lab in an age of MDROs

■ Envisioning the infection preventionist of the future

CNE/CME Questions

1. The Society for Healthcare Epidemiology of America, the Infectious Diseases Society of America, and the Pediatric Infectious Diseases Society issued a policy statement recommending which of the following?
 - A. Require antimicrobial stewardship programs through regulatory mechanisms
 - B. Monitor antimicrobial stewardship in ambulatory healthcare settings
 - C. Educate clinicians and the public about antimicrobial resistance and antimicrobial stewardship
 - D. All of the above
2. In seeking regulatory action mandating antibiotic stewardship, the infectious disease groups asked which group to enact the measure?
 - A. Food and Drug Administration
 - B. Centers for Disease Control and Prevention
 - C. Centers for Medicare and Medicaid Services
 - D. Occupational Safety and Health Administration
3. According to a study with data from Veterans Administration hospitals nationwide, what proportion of IV fluoroquinolone days out of all fluoroquinolone days is unnecessary and potentially avoidable?
 - A. 46.8%
 - B. 33.2%
 - C. 28.1%
 - D. 17.0%
4. In a study examining the impact of having infectious disease physicians identify patients who do not need to be discharged on community-based parenteral anti-infective therapy (CoPAT), investigators found that what number of the 69 patients for whom IV antibiotics were stopped were readmitted for infection within a 30-day time period?
 - A. 54
 - B. 35
 - C. 21
 - D. Zero

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The Joint Commission Update for Infection Control

News you can use to stay in compliance

HAI a high priority: Joint Commission gives infection prevention its own web portal

‘We have both carrots and sticks.’

In yet another sign that infection control is becoming a national priority across a wide range of accreditors, regulators and state and federal agencies, the Joint Commission has created a new web portal to combine its full array of initiatives to prevent health care associated infections (HAIs).

“[We] have many moving parts that affect many aspects of health care,” says **Jerod M. Loeb**, PhD executive vice president for health-care quality evaluation at the Oakbrook Terrace, IL-based accrediting agency. “We have standards, performance measures, our center for

transforming health care. The problem has been that they have all been located in silos.”

The “HAI Portal” enterprise includes the Joint Commission Center for Transforming Healthcare, Joint Commission Resources, and Joint Commission International. The goal of the HAI Portal is to provide an integrated “kiosk” of HAI resources — including those that are free and for purchase — in one web view that is accessible through any of the Joint Commission related websites. Yes, there are Joint Commission related products for sale on the site, but Loeb says that was not the primary driver of the

Key HAI topics on new JC portal

The Joint Commission Healthcare Associated Infection (HAI) portal lists resources under three headings:

HAI Topics

- General
- Catheter-Associated Urinary Tract Infections (CAUTI)
- Central Line-Associated Bloodstream Infection (CLABSI)
- Influenza
- Multi-Drug Resistant Organism (MDRO)
- Surgical Site Infections (SSI)
- Ventilator-Associated Pneumonia (VAP)

Infection Prevention and Control

- Environment of Care
- Hand Hygiene
- Patient Education
- Sentinel Event

- Staff Education
- Standards, National & International Patient Safety Goals

HAI by Setting

- Ambulatory Health Care (Includes Office-Based Surgery)
- Behavioral Health Care (Other than acute inpatient care)
- Critical Access Hospitals
- Home Care
- Hospitals
- Laboratory Services
- Long Term Care

The new Joint Commission Healthcare Associated Infection (HAI) portal can be accessed at <http://www.jointcommission.org/hai.aspx>. ■

project.

“It was not built to be a marketing site,” he says. “But just knowing a standard and knowing the elements by which a hospital might be surveyed doesn’t give them all the other answers. So we have created a variety of tools and things that are available — many of which are free. If you are an accredited organization, for example, you can turn to our leading-practice library. If you have issues related to getting house staff to wash hands prior to central line insertion, for example, you can find dozens of things that other organizations that we accredit have identified as good solutions.”

Other topics addressed on the site include, multidrug-resistant organisms, surgical site infections, catheter-associated urinary tract infections, and ventilator-associated pneumonia. (*See box, p. 1.*) The portal also includes resources on influenza, staff education and vaccinations.

“HAIs are harmful for patients, costly for health care organizations and largely preventable,” Loeb says.

Indeed, the Joint Commission has clearly separated itself from the old dogma of inevitable HAIs that reigned over health care epidemiology for decades.

“The mindset has changed radically,” Loeb says. “This [new view of HAIs] is sort of a huge amalgam at the national level, and we have a very important responsibility as an accreditor. We have a pathway that can help organizations comply with best practices, and that is called the accreditation process.”

The tightened focus on HAIs comes against the backdrop of unprecedented national activity on infection prevention.

“I think we were actually ahead of that curve with respect to the Joint Commission standards that have been on the books for years as well as our patient safety goals,” he says. “Clearly it is a national issue, but we have been involved in this for a long, long time. I do think that the stakes have changed with respect to issues around incentive payment, value-based purchasing and hospital-acquired conditions. The national attention associated with anything about HAIs is high.”

The long shadow of the CMS

Indeed, in the shadow of an increasingly active Center for Medicare and Medicaid Services (CMS) — the federal agency that gives it

deeming authority to grant accreditation — the Joint Commission is not likely to become less aggressive in the survey process. (As we previously reported, the CMS will begin unannounced inspections of infection prevention and hospital employee health programs later this year.)

“We certainly have worked closely with them and we will continue to work closely with CMS as part of our deemed status relationship,” Loeb says. “People and professional societies can preach it, but if nobody is validating whether [infection control] is done or not, things often don’t change. We have an interesting perspective here because we have both carrots and sticks. This portal is, we believe, a large carrot.”

Of course, what infection preventionists and other clinicians are hoping is that the multiple oversight groups and recommending bodies trend toward standardization and collaboration, unifying the rules and making the expectations crystal clear.

“At the national level there is an awful lot of collaboration going on,” he says. “We hope that the easily accessible information on the HAI Portal will assist health care organizations, practitioners and caregivers to prevent HAIs in their organizations, practices and homes.”

In that regard, while hospitals are expected to be the primary users, the Joint Commission designed the site to be accessible to a wide spectrum of health care settings and users.

“These are things infection preventionists, nursing home staff, health aides in a home health agency that we might accredit, all may want to know,” he says. The HAI site may set the standard for similar web portals at the Joint Commission, Loeb adds.

“We decided to create a single door, a portal to get the [HAI] information that you might be seeking,” he says.

However, in doing so, the Joint Commission was wary of creating a “menu” for standard compliance that could blunt critical thinking.

“If you open this portal and you are having a problem with a standard ‘X,’ you can utilize the tools,” he says. “But we tried to be careful not to make this an artificial lock and key, forcing people to begin thinking they are doing ‘X’ because the Joint Commission says you have to comply with ‘X.’ We tried to get away from that mentality and mindset.”

The Joint Commission HAI portal can be accessed at <http://www.jointcommission.org/hai.aspx>. ■

JC surveyors looked at IC ‘everywhere’

Documentation, medications also key

One hospital’s survey experience suggests Joint Commission surveyors will remain highly interested in infection control even if your health care associated infection (HAI) rate is low.

Such is the take-home lesson from the first Joint Commission survey for **Elizabeth Donnemwirth**, RN, accreditation/sharps safety specialist at Winchester Hospital in Winchester, MA. The week-long survey for the hospital, which has 189 licensed beds, was performed by two nurses, a physician, and a life safety specialist. Surveyors looked at the usual suspects: infection control, documentation, medication, and competencies, she says. Coming in December 2010, right under the wire for the changes coming in the life safety/environment of care surveys, she says, surveyors also focused on EOC issues such as clutter.

Unlike the Centers for Medicare & Medicaid Services’ surveyors, who “start from the patient and work up,” she says, The Joint Commission surveyors asked some patients questions, “but they didn’t really focus on patient communication, not from the perspective of speaking to patients. They were very focused on communication in general.”

She notes that the surveyors touched on every standard in the manual, but was still somewhat surprised at “the extent that they focused on infection control because we have extremely low infection rates.”

As the time rolls on post-survey, she’s hearing more and more from staff in particular areas. “Being the accreditation specialist, I was neither escort nor scribe. I was involved in one area with a question-and-answer session with the physician surveyors when they were already in the ED talking about something else, and I came to answer a question.”

She says the hospital has an ambulatory care unit on site, but it’s very small; the hospital itself is 100 years old. So there are a lot of offices off-site. Many of the endoscopy nurses visit the off-site clinic, going back and forth from the on-site to the off-site office. The surveyors watched the processes there, specifically

surrounding cleaning the scopes for colonoscopies. Donnemwirth wasn’t surprised that they went to the off-site clinic, as surveyors usually go to at least 50% of your off-site clinics, she says. The surveyor looked at the drying racks for the scopes and looked at the floor and said, “Oh good, no brown spots.”

Staff “looked at him, and they were appalled that he would even think he would see that, and he said, ‘Oh, you’d be surprised.’” Surveyors do seem to compare hospitals and have their own pet peeves, she says. “One of my personal things is hand hygiene and cleaning scopes and things like that. I also do sharps safety, so I’m really fussy about that kind of stuff. And these surveyors have their own [peeves]. One of the surveyors, the home care surveyor, was also a home care nurse so she did the home care survey. That’s where she felt comfortable, and they had a good review even though she was tough with the questions. But she also came into the hospital and did a lot of infection control stuff and spoke to patients in isolation.”

Surveyors surprised — in the right way

Overall, she says, surveyors were surprised by the size of the hospital and how well they were doing “because apparently a lot of smaller hospitals have more difficulty because you have one person wearing a lot of hats.”

They emphasized documentation and policies, she says, and asked to see many files. They asked for an OR block time for a particular surgeon and spoke with her about how she schedules. Surveyors looked at physical and occupational therapy for the rehab perspective. “They asked, of course, in all the sessions, to see a lot of information straight out of the data,” she says.

As for infection prevention, she says, “everywhere they went, they looked at the infection control aspect of it.” The surveyors asked about the solution that’s put into the whirlpool bath to keep it free of bacteria and the processes involved. They asked a housekeeper how she prepares that solution and how she could ensure that it’s the same every time. Donnemwirth says that process has been standardized so that all that is needed is for a staff member to push a button and the solution is mixed perfectly.

“[I]t’s pre-measured in this machine,” she says. “And the company that supplies us with this comes every month to make sure that it’s measuring exactly the right amount ... In some

hospitals, they have to measure it. So how do you know it's perfect?"

Joint Commission surveyors also looked at all the containers for labeling. Even the solution used to clean the tray and table area after scopes are cleaned has to be labeled, she says, because it's a "secondary container."

Overall, the hospital received kudos for staff working well together. Surveyors "could tell it wasn't put on for survey week. That [staff] truly did work well together. The communication, hand-offs, things like that, they were very impressed with." Surveyors also complimented nursing documentation and nursing patient care plans. "One of the things we were told they would focus on, and they did, was care plans. You look at the patient assessment and then [ask], 'Were those things that were identified put into the care plan?'" For example, if a patient is identified for falls risk, how is that implemented and checked on?

"So they drilled down to, 'OK, you identified these four things when the patient was admitted in the first 24-hour admission assessment. And now, how do you know that you're addressing them? And how do you know that it's resolved? And what happens when, OK that goal is done and you have a new goal? How do you identify a new goal?'... They were very impressed with that," she says.

In addition, the surveyors looked at legibility involving histories and physicals. "We did find some entries where timing was missing, so we did get hit on that," she says. Staff are "pretty good" with dating, she adds, but have not been so consistent with timing, specifically in certain areas. The hospital is only half-electronic. So timing may not be as good in some of the off-site clinics not yet on an electronic system but better in the hospital because of CPOE. The hospital also got cited for hospital clutter, certainly no uncommon finding.

"Some of the nursing units are larger than others in terms of room size," she says. Surveyors found in some hallways a couple of IV poles, a computer on wheels chart, and linen carts. Moving forward, she says, linen carts are going to be put inside patient rooms. Nursing and housekeeping, she says, are actually happy about the change, which will make their jobs easier.

She suggests asking any and all questions you may have for the surveyors while they're there. The more clarification you can get, the better, she says. ■

Gown use for isolation remains a judgment call

But consider high toll of HAIs

The question of gown use when entering patient isolation rooms is a recurrent one, so it is worth noting that this is the current thinking of the Joint Commission on the subject:

Joint Commission standard IC.01.05.01 EP 1 states: "When developing infection prevention and control activities, the organization uses evidence-based national guidelines or, in the absence of such guidelines, expert consensus." The guideline that addresses contact precautions is published by the CDC's Healthcare Infection Control Practice Advisory Committee (HICPAC).

Recommendation V.B.3.b.i. from the HICPAC guideline states, "Wear a gown whenever anticipating that clothing will have direct contact with the patient or potentially contaminated environmental surfaces or equipment in close proximity to the patient. Don gown upon entry into the room or cubicle. Remove gown and observe hand hygiene before leaving the patient-care environment."

Joint Commission surveyors will expect healthcare workers to wear a gown if their "clothing will have direct contact with the patient or potentially contaminated environmental surfaces or equipment in close proximity to the patient". The difficulty lies in "anticipating" when this may occur. For example, it is very probable that a nurses' aide preparing to perform a bed bath will have contact as described above, and therefore a gown would be expected. However, one of a large group of residents performing rounds with an attending physician would have a lower likelihood of clothing contamination.

Each organization may decide what guidance to provide to its healthcare workers within the parameters provided by HICPAC. However, The Joint Commission encourages organizations to consider the high morbidity and mortality of healthcare-associated infections in our nation when deciding what constitutes "anticipated contact" in each facility. Additionally, organizations may want to discourage non-essential personnel from entering the rooms of patients on isolation precautions. ■