Infection control

Bringing down infection rates quickly
A Syracuse hospital brings above-average rates down to zero within a year

On June 31, the New York State Health Department released a report detailing the healthcare-associated infection (HAI) rates of hospitals in New York for 2008. SUNY Upstate University Hospital in Syracuse, NY, reported an alarming infection rate in the medical-surgical ICU. According to the report, University had a central line–associated bloodstream infection rate of 8.3 per 1,000 patient days in that particular ICU during the previous year. The state average in New York was 2.3.

The report forced University’s quality team to reevaluate its processes for infection prevention, particularly in the ICU, says Judy Kilpatrick, RN, clinical nurse specialist to the surgical ICU, trauma, and burns. Part of Kilpatrick’s job is to examine quality measures and determine what the hospital can do to improve direct patient care at the bedside.

“I think there were a number of contributing factors, and the way our system was set up, that didn’t afford an easy process for the practitioner to do the right thing,” Kilpatrick says. “When I talk to my colleagues, they have the same particular issue, so what we did is we implemented some things that would make it more efficient for the practitioner and at the same time institute some documentation procedures, which allowed us to go back and coach those people through the [Institute for Healthcare Improvement (IHI)] bundle.”

University kick-started a fast-paced improvement program to reduce central line infections in all ICUs throughout the facility. One year later, the hospital has reduced its rate to zero, says David Duggan, MD, medical director and quality officer.

“We have tried to look for solutions that make it easy for people to do the right thing, and I think that’s the key.” —David Duggan, MD

Why the rate was so high
Duggan explains that although infection control (IC) improvements have helped lower the HAI rate in the

After reading this article, you will be able to:
➤ Identify the 2008 infection rate at University Hospital
➤ Describe how staff members reduced the infection rate to zero
➤ Explain why public reporting is beneficial

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med-surg ICU, one of the primary reasons the rate in this particular six-bed unit was so high was because it was part burn unit and part general ICU.

“Burn units, when they are standalone units, are actually excluded from this measure because infections are so common in patients with burns,” Duggan says. “This unit was included because it did not have the majority of patients with severe burns, but still there was a component of the population there that was extraordinarily susceptible to infections.”

Shelley Gilroy, MD, hospital epidemiologist at University, explains that burn patients have an indigenous flora which results in more infections. “That’s why they are considered a high-risk group, and why we might have had an increase in the rate,” says Gilroy.

The unit was included on the report because it was technically a general ICU, but the numbers didn’t account for these susceptible burn patients, Duggan says. Still, a published infection rate that was almost three times higher than the state average elicited a primary focus on IC.

The initiatives have worked thus far. Through the second quarter of this year, University has posted infections in just three of its seven ICUs, all of which fell below the state average for each unit. So far this year, the med-surg ICU has posted zero infections.

Implementing the bundle

At the beginning of the year, University formed a multidisciplinary group of roughly 12 people with the task of implementing the IHI’s central line bundle. The group developed forms and documentation that included a checklist, one of the major parts of the bundle.

“During the procedure, it brought everyone together on agreed-upon techniques, such as not starting without the equipment necessary, the staff all communicating and staying in the room together during the procedure, and having the right equipment at the right time to do the job,” Kilpatrick says.

The group also implemented procedure carts for maximum barrier precautions to ensure that all the required equipment was at the bedside during the procedure.

All new residents and employees receive education about the bundle process, and the hospital has plans to implement its own bundle that will educate employees who provide central line maintenance.

“Everything in that bundle has been incorporated into practitioner education,” Kilpatrick says. “We hope over the next year to make up our own concept, which is called a maintenance bundle, to review with the people who are doing the dressings and maintain the catheters so we can keep that cleanliness throughout the catheter’s life.”

Source
Adapted from Briefings on Infection Control, December 2009, HCPro, Inc.
When patients come into the hospital with an illness or health problem, staff members must do all they can to help patients improve during their stay. Staff members must also ensure that patients take care of themselves upon leaving to prevent a rehospitalization.

Congestive heart failure (CHF) is a health problem that requires special care and follow-up for patients.

Dickinson County Healthcare System (DCHS) in Iron Mountain, MI, and Smithville (TX) Regional Hospital (SRH) each decided to revamp their CHF discharge instructions to help avoid CHF patient readmission. As a result, both facilities saw a drop in their readmission rates and a general acceptance of discharge instructions from patients and staff members alike.

Common ground shared between facilities

Along with preventing readmission, both facilities wanted to improve their compliance with CMS requirements and make improvements to their quality initiatives.

However, prior to each facility deciding to revamp their CHF discharge instructions, Jeanette Parent, RN, nursing education coordinator at DCHS, and Julie Miller, RN, quality director at SRH, each received information to help them take that initial step toward developing the instructions.

Parent says the review analyst team at DCHS found that the facility was consistently failing the written discharge part of Core Measure Standard #1 for CHF. Based on this finding, Parent and other staff members at DCHS set out to develop the discharge instructions to help comply with this standard.

Meanwhile, Miller says her facility didn’t necessarily see an increase of readmissions, but it did see a potential for increase based on evidence-based standards referenced by CMS’ Quality Initiatives.

“We developed the patient teaching sheet to assist us in making sure the patients got the information they needed to manage their disease after discharge,” says Miller. “One of the quality initiatives was to prevent readmission.”

SRH provides weight monitoring calendar

Although the CHF instruction sheets at both facilities are designed to educate patients as they leave the facility as well as prevent readmission, there are some differences.

One of the main reasons for developing SRH’s instruction sheets was the fact that the facility did not have electronic medical records.

“Nurses would forget to document whether or not they had educated the patient on weight monitoring and basic follow-up information,” says Miller.

The two-page Patient Information on Heart Failure document (see pp. 5–6) was developed using resources from the TMF Health Quality Institute, formerly known as the Texas Medical Foundation.

On the first page is a list of symptoms to watch for when patients return home. These symptoms may indicate that a patient’s CHF is worsening and that he or she should contact his or her physician.

At the bottom of the first page is a line for the patient to sign and date. Once the patient has signed, one copy goes into the patient’s records, and the other is sent home with the patient.

The second page of the CHF instructions focuses on weight monitoring.

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**Patient care**

“Due to the fact that CHF can cause the patient’s body to retain water, it is important that the patient weighs themselves regularly,” says Miller.

The instruction sheet provides three calendar sheets where patients can monitor their weight and get in the habit of doing it every day.

Along with the CHF discharge instructions, patients are given instructions on when to follow up with their doctor. The follow-up appointment varies, depending on the individual patient. It can range anywhere from three to seven days.

**DCHS’ checklist and follow-up phone calls**

At DCHS, the CHF discharge instructions are slightly different. DCHS felt that nurses were educating patients but failed to document their teaching.

Parent and a team consisting of the review analyst, the manager of medical and ICU, representatives from nursing education, and the case manager, devised the Heart Failure document that is distributed to CHF patients.

“We give any inpatient that has the diagnosis of CHF as their principal diagnosis and/or has a secondary diagnosis a teaching sheet for CHF,” says Parent.

The one-page teaching sheet lists the definition and symptoms of CHF as well as general information about the disease.

The general information portion of the teaching sheet includes instructions for patients to follow when they return home. Some of these instructions ask CHF discharge patients to:

- Weigh themselves daily in the morning, on the same scale, wearing similar clothing
- Avoid drinking softened water—salt is used to soften it
- Limit intake of caffeine and alcohol
- Keep regular physician appointments
- Check pulse prior to and after taking medications such as Digoxin/Lanoxin®

Parent says even after DCHS initiated this teaching sheet, it was still seeing repeat readmissions.

“The case manager noticed that we were seeing one or two patients with three to four admissions over several weeks due to noncompliance,” she says.

To help prevent this, the case manager worked with the cardiac rehabilitation manager to provide ongoing education for patients discharged with CHF.

As part of this ongoing education, an RN from the cardiac rehabilitation center was tasked with calling each patient at home. The RN would ask patients whether they were taking their medication, what their weight was, and how they were feeling. The RN would also send educational material to CHF patients every week for six weeks.

**Results and acceptance**

After implementation, SRH patients were receptive to being educated on their disease, and the doctors found the CHF discharge information to be helpful because patients were ready with the information, says Miller.

The CHF discharge information has been so well received that SRH has begun development of similar patient education forms for patients diagnosed with pneumonia.

At DCHS, patients and their families really liked the instruction sheet because they were able to return to it as a reference, says Parent.

Asked what they would do differently, Parent and Miller say they would get the nurses more involved next time around because they can bring their real-life experiences to the project.

“Include your staff more; once they have an understanding of why we need them to review yet another piece of paper with patients, they jump on board,” says Parent.

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**Source**

Adapted from *Briefings on The Joint Commission*, October 2009, HCPro, Inc.
Patient Information on Heart Failure

When you have heart failure, you may have re-lapses or flare-ups. It is important to call your doctor if you notice any changes in your body.

Things to watch for include:
Swelling
• Puffiness in your feet or ankles
• Your shoes feel tight
• Your clothes feel tight
• Your rings are difficult to put on or take off

Shortness of Breath
• You are breathing harder, even when you are resting
• You feel like you cannot catch your breath
• You wake up coughing or short of breath
• You are using more pillows or even sitting up to sleep

Other Signs to Watch for...
• Weakness, dizziness or fatigue
• Chest pain
• Irregular heartbeat or racing heartbeat
• Loss of appetite
• Weight gain

Other Important Information...
• Limit your fluid and sodium intake as directed by your physician. These cause excessive overload on your heart
• Do not smoke and avoid smoke exposure

Call your doctor immediately if you have any of these signs or any unusual symptoms.

Patient Signature: ___________________________ Date: __________
Weight Monitoring

Heart failure can cause your body to retain water. This extra water makes our heart work harder. Keeping a record of your weight will help you and your doctor watch for water retention.

How to monitor your weight:

- Always use the same scale to weigh yourself.
- Make sure your scale is on a hard, flat surface.
- Weigh yourself every morning;
  - Weigh yourself after you urinate
  - Weigh yourself before you eat or drink
  - Weigh yourself wearing the same clothing (nightclothes, undergarments, or nothing at all)
- If you miss a day, just weigh yourself the next morning as usual
- Record your weight in the chart below
- Bring your weight chart whenever you see your doctor.

Call your doctor immediately if:

- You gain 2 pounds in one day
- You gain 3 to 5 pounds in one week

Created by Smithville (TX) Regional Hospital. Reprinted with permission.
Encouraging staff members to submit posters for presentation at local and national conferences or other educational settings is a great professional development opportunity. The following discussion will give you some pointers on preparing posters and submitting them for review.

**Tips for preparing an abstract**

A poster abstract is generally submitted in narrative form, without visual aids. Therefore, start by choosing a catchy title. It should stand out from the many other abstracts that will be received. For example, which would you most remember: “Analysis of evidence-based data to justify department expansion” or “Departmental expansion: Gathering evidence to promote education!”?

Describe your project concisely, relying on major points of interest. You’ll only have a limited number of words to do this, so cover information such as the purpose of the project, highlights of its implementation, and outcomes. If you have templates, tools, or forms that are original and important to the success of the project, describe them briefly. Committees reviewing abstracts will want to quickly grasp the essentials of your project, how it will add to the body of knowledge of the participants, and what unique or original outcomes resulted. Also include what important information participants will be able to take away from your poster and use in their practice settings.

Finally, follow all guidelines for submission meticulously. Don’t forget to spell-check your work and make it as easy as possible for the reader to understand. Ask several colleagues to review your abstract before you submit it, and be sure to ask people who are not directly involved in the project. You want to be sure that your abstract makes sense to someone reading it for the first time.

**Poster preparation and presentation**

Use visuals that are appealing, clear-cut, and easily understood. Use narrative information to describe essential points of interest. Make sure that you use a font size and style that can be read from several feet away. Stick to one or two fonts, such as one for major headings and another for text. Using too many different styles can be distracting and difficult to read, and can take away from the educational aspects of the poster.

Use illustrations, but only those that help to educate attendees. Pictures of people participating in the project, sample forms or templates, and graphs are all good examples. As with the text, make sure that the illustrations can be viewed and understood from several feet away.

Include educational objectives, names and titles of presenters, and the represented organization as parts of the poster. Make sure that all acronyms are spelled out in their entirety the first time they are used, followed by the acronym in parentheses. Never assume that an acronym will be recognized by all attendees.

Finally, the following are some tips regarding your behavior as a poster presenter:

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➤ **Dress professionally but comfortably.** Wear comfortable business shoes, but not sneakers. You will most likely be standing for several hours, so plan ahead. You are representing yourself and your organization, so it is important that you are businesslike in appearance and demeanor.

➤ **Be confident.** If you appear uncomfortable or are unable to answer questions, you will make a poor impression. Ask colleagues to quiz you prior to the presentation so you can practice. Have them ask you various questions about your project, including tough or cynical questions, so you can be prepared for both praise and criticism.

➤ **Have a good supply of handouts available.** Nothing irritates participants more than finding out that an excellent poster presenter did not bring handouts or failed to bring an adequate supply. Include details in your handouts that may not have had room to include on the poster.

➤ **Bring an adequate supply of business cards.** You may want to bring a small table or stand with you and use it to display handouts and business cards. That way people who want to contact you later or who do not have time to talk to you will be able to take away information.

➤ **Have a small basket or other container and encourage participants to leave their business cards with you.** Never miss an opportunity to network.

➤ **Consider including a basket of candy or other giveaways such as pens or sticky notes at your table.** Sometimes people are more likely to stop and view a poster when they see that a gift is part of the presentation.

➤ **Come prepared to make emergency repairs.** Extra copies of tools, illustrations, or narratives may come in handy in case of a rip or spill. Also bring extra pens, markers, double- and single-sided tape, and thumbtacks. You never know what repairs may need to be made.

➤ **Stow valuables securely or don’t bring them.** If you bring items such as a purse or laptop, keep them in a secure place, never in view of attendees. You will be busy answering questions and will not be alert to the whereabouts of your valuables.

➤ **Enjoy yourself.** A poster presentation is an excellent opportunity to share your knowledge and proudly display your accomplishments.

➤ **Make time to view other posters and talk to their authors.** You will doubtlessly pick up tips for your next poster presentation. You will also acquire knowledge that you can use in your own practice setting.

If your first poster abstract is not accepted, don’t be discouraged—just keep trying. Presenting posters, like any form of presentation, is an art and worthy of pursuing. It may lead to publication of manuscripts or future podium speeches. The sharing of knowledge is both a responsibility and a pleasure for staff development specialists.

### References


### Source

Adapted from *The Staff Educator*, October 2009, HCPro, Inc.
Patient safety

Planning ahead to change behaviors

Patient Safety First campaign focuses staff and patients on a common goal

Keeping many new patient safety topics and initiatives fresh in the minds of frontline caregivers can be a challenge.

To ensure that staff members were thinking about a new aspect of safe patient care each month and to educate employees and patients about patient safety goals, Abington (PA) Memorial Hospital (AMH) started Patient Safety First, a hospitalwide campaign focused on behaviors and actions. Originally launched in 2008, staff members decided to continue building on Patient Safety First after seeing success in its first year. The program was originally developed as a means of coordinating the large amount of safety information disseminated to frontline caregivers.

“It was a program to help us focus, inform, and partner with our employees and patients to get the patient safety message out,” says Robert C. Giannini, NHA, safety/quality specialist at AMH’s Center for Patient Safety & Quality. “It’s really letting staff and our patients be on the same page for the month.”

New month, new topic

This year, AMH created communication strategies for internal staff use as well as some specifically for patients.

At the end of 2008, staff members outlined a full calendar year of topics for each month in 2009 to help show staff members that the program is a part of the organization’s underlying mission, says Giannini.

“We do change our goals based on our priorities for that year,” he says. “People are seeing that this isn’t going away and it’s part of our culture.”

To really drive home the idea of changing behaviors to improve patient safety, Giannini and his staff designed the campaign to be apparent in the everyday work environment.

Depending on the month’s theme, the topic receives attention on screen savers, in the Nursing Notes internal newsletter, in posted educational pieces, and via patient safety coaches, who spread the theme to fellow caregivers.

The patient safety coaches meet monthly to discuss new hospital initiatives. Safety coaches at AMH are frontline caregivers who are unit-based and share a specific message with their colleagues. This coaching team is effective in spreading behaviors and new projects or ideas with their peers.

“We do have safety coaches in each area of the hospital, and [the monthly Patient Safety First topic] would be part of the theme of the meeting that month,” says Linda Mimm, RN, BC, DL, CPHQ, safety/quality specialist at AMH’s Center for Patient Safety & Quality. “It’s not just a piece of paper that goes out, it’s a clear team effort getting the message out also.”

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Giannini and his staff ensure that hospital employees understand how each month’s theme fits in with The Joint Commission’s (formerly JCAHO) National Patient Safety Goals (NPSG) as well as the organization’s annual goals. Some of the topics are reflective of pressing issues in the field, such as CMS’ never events or other quality initiatives.

Equally important to the success of this initiative has been the nursing department’s ability to partner and plan with the finance department, says Elizabeth Medina, RN, BSN, CCRN, nurse manager for the cardiac surgery and cardiac ICUs at AMH. After all, nurses are a part of the team targeted by this initiative. “We have a good support structure within the nursing department because we partner with finance,” says Medina. “What gives us the capability to partner with things like this is we structure into our own unit budgets for the fiscal year training and orientation hours that allow me to pull out specific [full-time equivalent] hours [each] month to get people off of my unit, to go to meetings, and then also to get the publications onto the bulletin boards in the units and posted to the unit intranet sites.”

Patient education

Staff members in the quality/safety department develop patient education materials to alert patients to each month’s theme. For example, in January, AMH distributed flyers informing patients that hand washing was a focus that month and asked them to be partners in their own safe care.

The patient education flyers are posted on a bulletin board in each room and placed in patients’ folders (each patient receives a folder when he or she enters a specific unit, whether via new admission or transfer). Staff nurses introduce the monthly patient safety theme while reviewing other important information about patients’ stays.

Overall, the initiative has helped the hospital as a whole incorporate many aspects of patient safety into patient care and focus on specific topics for improvement. AMH has seen an increase in reports of concerns, suggestions, and patient safety events from staff members and patients.

“Working in the safety/quality department, it really helps us focus as an organization on a theme,” says Mimm, who tries to incorporate each month’s theme into her task of supporting and publicizing the NPSGs. “When there’s so much going on in healthcare and so many demands on the staff, it really helps us all focus.”

12-month Patient Safety First calendar

Abington (PA) Memorial Hospital (AMH) used the following list of themes for each month in 2009. These were planned in advance so staff members had an idea of what to look forward to:

- **January:** “Wash” (hand washing)
- **February:** “Briefings” (caregiver meetings about patient condition)
- **March:** “C.A.R.E.” (communication, access to information, resources, and education—AMH’s daily care plan)
- **April:** “Identify” (patient identification)
- **May:** “Be Alert” (awareness of medication safety)
- **June:** “Report” (critical tests and results)
- **July:** “Protect” (provision of a safe environment to reduce adverse events)
- **August:** “Communicate” (focus on active communication)
- **September:** “Prevent” (awareness of how to prevent patient falls)
- **October:** “Immunize” (focus on staff immunization)
- **November:** “Reconcile” (better reconciliation of medications)
- **December:** “Speak Up” (preventing an adverse event from occurring by “stopping the line”)

Source
Adapted from Patient Safety Monitor, December 2009, HCPro, Inc.
Accreditation

Don’t put patients in egress halls when ED overcrows

The Joint Commission is against such actions

Those who plan to move patients into exit corridors when routine ED overcrowding occurs may want to reconsider, given what a Joint Commission official said about the matter.

Patients on gurneys and chairs cannot be parked in egress corridors because of Life Safety Code® requirements for minimum clear widths, George Mills, FASHE, CEM, CHFM, senior engineer at The Joint Commission (formerly JCAHO), said during a Joint Commission Resources audio conference May 6.

Even if state regulators order healthcare facilities to get patients out of EDs and hold them in inpatient unit corridors, The Joint Commission doesn’t think this is the best approach, Mills said.

Instead, facility managers and ED directors should review ED traffic flow and come up with better ways to manage overcrowding.

An exception to this requirement is a disaster-related influx of patients to a healthcare facility, during which corridor treatment of patients may be the only way to deal with the sudden surge.

Dealing with ED overcrowding

The issue of what to do about overflowing EDs is contentious. The Massachusetts Nurses Association clashed earlier this year with Saint Vincent Hospital in Worcester, MA, about putting patients awaiting discharge in hallways to make room for ED patients waiting to be admitted.

Saint Vincent’s move came in reaction to the state Department of Health’s January edict that hospitals can’t divert ambulances to other healthcare facilities to avoid ED overcrowding.

Saint Vincent’s policy of moving patients awaiting discharge into hallways has been used at least once this year. “A patient who was awaiting discharge was moved from his room to the hallway adjacent to the nurses’ station in order to make his bed available for an admitted ED patient, who required treatment on the inpatient telemetry unit,” the hospital said in a statement.

The Joint Commission’s stance is a surprise to Dennis Irish, spokesperson for Saint Vincent, especially given that the Massachusetts Department of Health and the state fire marshal have stated that patient boarding in hallways can work within fire safety requirements.

In a letter to local fire chiefs that was posted online, the Massachusetts fire marshal notes the Department of Health’s new overcrowding policy. The letter asks chiefs to work closely with hospitals in their communities to understand defend-in-place and egress strategies in the event patients are boarded in corridors.

Saint Vincent’s policy is to put boarded patients in wheeled chairs, not gurneys, in the hallways on the rare occasions when the ED is in danger of being overpopulated, Irish says. “It’s a last resort,” he added. “It’s only happened once.”

Before boarding patients in corridors, the hospital takes other steps, such as attempting to open more beds on care units.

Saint Vincent’s efforts have met with approval from state regulators, Irish said. It’s possible this issue will come to a head the next time The Joint Commission surveys the facility based on the differences between the state’s and the commission’s stances, he said.

Generally, The Joint Commission expects facilities to observe the stricter of two approaches when there is a conflict in requirements. Given how controversial ED overcrowding has become in the industry, it is worth comparing The Joint Commission’s opinion to the overcrowding procedures your facility currently engages in.

Source
Adapted from Healthcare Life Safety Compliance, July 2009, HCPro, Inc.
**Tip of the month**

**Confronting nurses over unacceptable behavior**

Kathleen Bartholomew, RC, RN, MN, is well known for her work related to nurse-to-nurse hostility. She also teaches us that many unacceptable behaviors result from managers who are unwilling to confront situations.

The following situations are ones where managers must hold a conversation in a timely manner:

- A policy or procedure was not followed
- Poor clinical judgment resulted in a bad patient outcome
- Unsupportive work environment
- A work environment built on cliques
- Disrespectful or condescending language
- Misuse of authority by a nurse in a senior position

Confronting situations isn’t easy, but it is essential. To get started, consider using the DESC model created by Sharon Cox, RN, MSN, CNAA:

- **D (Describe the facts):** "I noticed you turned your back and walked away just as I approached you."
- **E (Explain):** "This makes me feel you are avoiding me."
- **S (State):** "As your manager, I need to know that you and I can communicate whenever necessary."
- **C (Consequences):** "If you continue to avoid me, we will address this at a formal disciplinary meeting in my office. We cannot provide safe patient care if I cannot communicate effectively and timely with the staff."

Reference


Source

Shelley Cohen, RN, BS, CEN, Health Resources Unlimited, [www.hru.net](http://www.hru.net). Adapted with permission.

Sharon Cox, MSN, RN, CNAA. Cox & Associates.