

## ***Infection Monitoring in Rural Hospitals— Systems & Practice***

Improving the "Infection Monitoring and Reporting Process"



### **AIM STATEMENT**

By July 31, 2010, our HSAG Infection Control Team will develop an Infection Control Team that will meet on a every other month basis (core team monthly ad hoc).

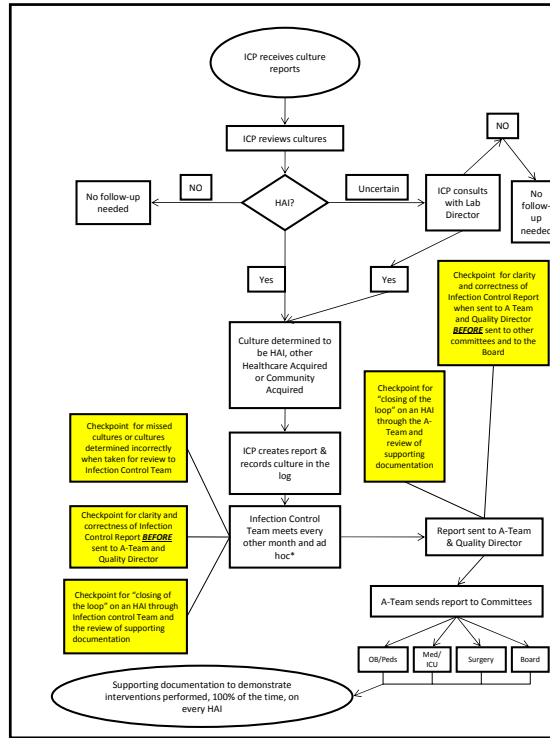
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The team will create supporting documentation to demonstrate interventions that were performed, 100% of the time, in the case of an HAI.

## TEAM CHARTER

<b>Clinical Discipline/Service Team Name:</b> INFECTION CONTROL TEAM	
<b>Administrative Sponsor:</b> Roberta Johnson, RN, CNO	
<b>Team Chair:</b> Penni Padgett, RN, IP (core member)	
<b>Team Vice-Chair:</b> Sandra Montgomery, Laboratory Director (core member)	
<b>Team Membership:</b>	
Med/Surg staff member or director	Imaging staff member or director
CR/CS/OPS/PACU staff member	Physician representative-Hospitalist (core member)
OB/Nursery staff member	Pam Wendall, RN, MSN Quality Director (Core member)
EVS/Dietary staff member or director	
Pharmacy director	
Cardiopulmonary staff or director	
<b>How are decisions made in the team?</b>	
Data analysis and chart review, Research of literature.	
<b>To whom and how often does team report it's activities, barriers and results?</b>	
To Quality monthly To Administrative Team monthly who in turn reports to Governing Board, Medical Staff Committee, Surgery Committee and OB/Gyns Committee	
<b>Frequency of meetings:</b> every other month and core team monthly ad hoc	
<b>Purpose of Team or description of process(es) for improvement (attach process map)</b>	
<b>Name of process(es):</b>	
Monitor and review microbiology cultures monthly Monitor VAP, CRBSI, CAUTI, MRSA, AND MDRO Review hospital wide issues related to infection control and make recommendations Ensure that hospital is meeting all infection control Regulatory Agency requirements	
<b>AIM Statement</b>	
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<b>Key measures (Indicate process or outcome)</b>	
Decrease number of HAI	
Maintain current level of infection control practices.	
No deficiencies on surveys by regulatory agencies.	
<b>Key Goals &amp; Deliverables</b>	
	<b>Timeline</b>
Develop Team	July 31, 2010
Conduct first team meeting	August 2010
Develop Tracking and trending tools for CAUTI and CRBSI	December 31, 2010

NEW/PROPOSED  
PROCESS FOR  
TRACKING HAI'S  
"CLOSING THE LOOP"



### Infection Monitoring Initiative Implementation Plan

Implementation Questions	Response	Target Date
Who is the member of Executive Leadership that will officially approve the Team Charter, and when?	Neal Jensen, CEO	Aug 10
Who will be the Executive Champion for this initiative who will lead the development and execution of the Implementation Plan?	Roberta Johnson, CNO	
Who is the primary physician champion for this initiative?	Dr. Chandra Dr. Nguyen	
Who will be involved in the developing the Implementation Plan?	P. Padgett, RN P. Wendall, RN S. Montgomery, Lab Director S. Ericksmoen, LPN	
Who will be the Process Owner for this process change that will track performance, get feedback and input on progress and barriers, inform the members of the QI team, document any plans to redesign your processes or systems, and document changes in the process flow?	Penni Padgett, RN	
Is the Process Owner experienced in developing process flow charts and if not, how will that skill be developed?	With assistance from P. Wendall, RN	
How will all the people involved in making the targeted process successful learn about their individual responsibilities?	From leader/co-leader Individual meetings Infection control meeting	
How will the Board of Directors be informed about the initiative? (Tip: Use message from CEO)	Formal Presentation	June 10
How will the medical staff learn of the initiative? (Tip: message from CEO)	From CEO and CNO	
How will the hospital staff learn of the initiative? (Tip: Use message from CEO)	Message from CEO, Newsletter, Department Directors	
Who on the hospital staff needs to know the details about the new process and how it will be tested and how will they find out? (Tip: Use process flow chart)	No testing needed. Administration, Directors, Staff. Flow chart, Newsletter, formal presentations.	
Who on the hospital staff or medical staff has the greatest knowledge of proven methods for managing change and improving performance: and which method is it for? (i.e., Baldrige, Six Sigma, FOCUS PDSA Model, etc.)	Pam Wendall, RN FOCUS PDSA Model	
How will the Process Owner document any plans to redesign your processes or systems? (i.e., process flow charts, PDSA forms, meeting minutes)	Flow charts, COI tools, PDSA forms, meeting minutes.	
Who will lead the development of your Data Monitoring Plan?	P. Padgett, RN	
On what measures will you initially focus your attention?	HAI's	
Who will develop your Data Collection Tool?	Infection Control Team	

## Data Monitoring Plan

**Quality Improvement Initiative: Creation of Infection Control Team**

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**Key Measures, specifications and data sources**

Measure description	Measure calculation	Data source
100% of Resulted Inpatient cultures	Positive Cultures that were obtained more than 48 hours after admission to hospital.	Microbiology results for 100% of Inpatient cultures resulted for the month

1. Who will complete the data collection tool for each data element? **Infection Control Practitioner**

2. How often and when will the data be collected? **Monthly by the 10<sup>th</sup> of the month**

3. Who will receive the completed data collection tools? **Infection Control Practitioner**

4. How will the data be analyzed/tallied and by whom? **By the ICT and ICP**

5. How will the data be aggregated and tracked? **Monthly**

6. Who will the data results be reported to, how, and by whom?

- a. Admin Team (hard copy) by ICP
- b. Medical Staff Meeting (hard copy) by member of Admin Team
- c. Governing Board (hard copy) by CEO.
- d. Hospital Staff in newsletter, handouts at staff meeting
- e. Quality (hard copy & electronic)

7. How often will the data results be shared? **Monthly**

8. How will the data results be displayed? **Some type of chart to be determined**