



Ongoing Journey to an
Effective Infection Control
Team



OLD
Team consisted of
Infection Control Practitioner
and
Laboratory Director.
Not very effective

HOW WE GOT TO WHERE WE ARE TODAY

Attended HSAG Collaborative in 2010...information received and guidance
Helped in formulation a new IC Team for CVRMC.

Tools used:

Aim Statement

Team Charter

Letter from the Administrator (published in newsletter)

Flow chart (used in presentation to Governing Board and Admin Team)

Team presented to Admin Team

Team presented to Governing Board



"Our Mission is Your Health."

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). The team will review 100% of the infection control culture logs to concur determination of HAIs. The team will create supporting documentation to demonstrate interventions that were performed, 100% of the time, in the case of an HAI.



TEAM CHARTER

Clinical Discipline/Service Team Name: INFECTION CONTROL TEAM	
Administrative Sponsor: Roberta Johnson, RN, CNO	
Team Chair: Penni Padgett, RN, IP (core member)	
Team Vice-Chair: Sandra Montgomery, Laboratory Director (core member)	
Team Membership:	
Med/Surg staff member or director	Imaging staff member or director
OR/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	
How are decisions made in the team? Data analysis and chart review. Research of literature.	
To whom and how often does team report it's activities, barriers and results?	
To Quality monthly	
To Administrative Team monthly who in turn reports to Governing Board, Medical Staff Committee, Surgery Committee and OB/Peds Committee	
Frequency of meetings: every other month and core team monthly ad hoc	
Purpose of Team or description of process(es) for improvement (attach process map)	
Name of process(es): 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	
AIM Statement	
<i>By July 31, 2010, our HSAG Infection Control Project Team will develop an Infection Control Team that will meet on a every other month basis (core team monthly ad hoc). The team will review 100% of the infection control culture logs to concur determination of HAIs. The team will create supporting documentation to demonstrate interventions that were performed, 100% of the time, in the case of an HAI.</i>	
Key measures (indicate process or outcome)	
Decrease number of HAI	
Maintain current level of infection control practices.	
No deficiencies on surveys by regulatory agencies.	
Key Goals & Deliverables	
	Timeline
Develop Team	July 31, 2010
Conduct first team meeting	August 2010
Develop Tracking and trending tools for CAUTI and CRBSI	December 31, 2010

Letter from the Administrator

COBRE VALLEY REGIONAL MEDICAL CENTER's NEW Infection Monitoring Initiative!!
By Neal Jensen, CEO

COBRE VALLEY REGIONAL MEDICAL CENTER is one of ten Arizona Critical Access Hospitals that are voluntarily participating in the *Quality Improvement in Rural Hospitals—Systems and Practice (QI in Rural Hospitals—S&P)* collaborative, presented by Health Services Advisory Group, Inc. (HSAG) in collaboration with the Rural Hospital Flexibility Program at the Rural Health Office. The collaborative emphasizes the importance of a team approach using rapid-cycle improvement activities with concurrent monitoring of progress and results in order to be most successful with quality improvement efforts.

Through participation in this collaborative, CVRMC is aggressively aiming to hit a 100% target on our selected process for improvement: *By July 31, 2010 an Infection Control Team will be developed that meets on an every other month basis. The team will review 100% of the infection control culture logs to concur determination of HAIs. The team will create supporting documentation to demonstrate interventions that were performed, 100% of the time, in the case of an HAI.*

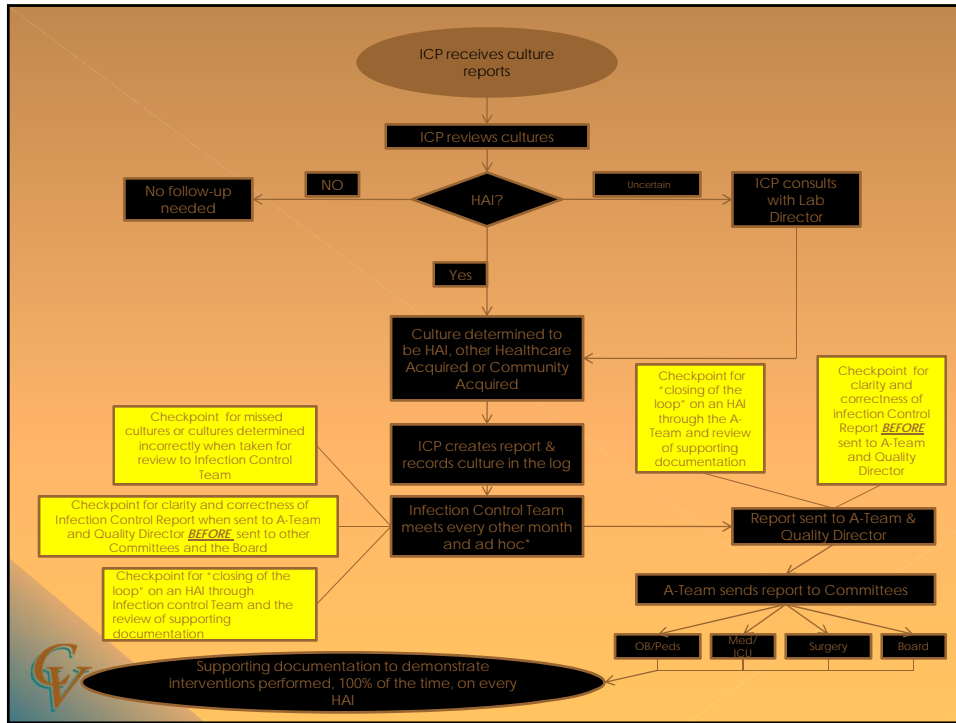
Our efforts will be designed, tested and coordinated by the Infection Control Committee acting as a Quality Improvement Team. The "team" includes all of the major players who need to give input and feedback on developing and testing our processes and systems to keep us informed "up-to-the-minute" on the results of our patient's potential infections. The team members are: Team Chair- Penni Padgett, RN IP; Vice-Chair - Sandra Montgomery, MT,DLM Laboratory Director; Pam Wendall, RN MSN Quality Director; Sue Ericksmoen, LPN; Dr. Chandra; Dr. Nguyen as well as members from OR/CS/OPS/PACU, OB/Nursery, EVS/Dietary, Pharmacy, Cardiopulmonary, Imaging.

The team will meet every other month to review Quality Improvement and organizational Infection Control issues and to approve Infection Control policies. *They will use well-known and proven methods to manage change and improve performance for targeted Key Measures.* All progress and barriers will be reported on an ongoing basis to Roberta Johnson who will serve as Executive Leadership's champion for the Infection Monitoring Initiative. In that way, Executive Leadership can address administrative and operational needs on a "real time" basis.

Some of the measures the team will be developing and monitoring include:

- Review hospital wide issues related to infection control, make recommendation and ensure that we are meeting all Infection Control regulatory agency requirements
- Monitor and review positive microbiology cultures, monitor Ventilator associated pneumonias, catheter related blood stream infection, and multiple drug resistant organisms.
- 100% of Inpatient Cultures will be reviewed to determine if there is a Hospital Associated Infection
- Reportable pathogens are received by infection control and reported on by the next business day of the culture being finalized.
- Patients are receiving the appropriate antibiotic therapy within 24 hours of culture being finalized

STAYED TUNED TO FIND OUT HOW YOUR JOB WILL BE INVOLVED IN HELPING US REACH OUR 100% TARGET ON THIS QUALITY INITIATIVE...



Where we are today

Team meets Bi monthly with representation from:

- Lab
- OB
- MS/ICU
- EVS
- Dietary
- ED
- Physician
- Cardiopulmonary
- Imaging

Projects taken on since inception:

- CAUTI teaching to Nursing (October 2010)
- Collection of Foley, Central line and Vent days (Started 1/1/11)
- C Diff notification to ancillary departments (Started (5/1/11)
- Needle Safety-Insulin Syringes (Changed to in April 2011)

Calendar for
Tracking
Foley Catheter Days
Central Line Days
And
Ventilator Days



MED/SURG Foley Catheter and Central Line Count (as of 0800 Daily)
MAY, 2011

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
1	2	3	4	5	6	7
Foleys:	Foleys:	Foleys:	Foleys:	Foleys:	Foleys:	Foleys:
Central Lines:	Central Lines:	Central Lines:	Central Lines:	Central Lines:	Central Lines:	Central Lines:
8	9	10	11	12	13	14
Foleys:	Foleys:	Foleys:	Foleys:	Foleys:	Foleys:	Foleys:
Central Lines:	Central Lines:	Central Lines:	Central Lines:	Central Lines:	Central Lines:	Central Lines:
15	16	17	18	19	20	21
Foleys:	Foleys:	Foleys:	Foleys:	Foleys:	Foleys:	Foleys:
Central Lines:	Central Lines:	Central Lines:	Central Lines:	Central Lines:	Central Lines:	Central Lines:
22	23	24	25	26	27	28
Foleys:	Foleys:	Foleys:	Foleys:	Foleys:	Foleys:	Foleys:
Central Lines:	Central Lines:	Central Lines:	Central Lines:	Central Lines:	Central Lines:	Central Lines:
29	30	31				
Foleys:	Foleys:	Foleys:				
Central Lines:	Central Lines:	Central Lines:				

ICU Foley Catheter, Central Line and Vent Count (as of 0800 Daily)
MAY, 2011

1	2	3	4	5	6	7
Foleys:	Foleys:	Foleys:	Foleys:	Foleys:	Foleys:	Foleys:
Central Lines:	Central Lines:	Central Lines:	Central Lines:	Central Lines:	Central Lines:	Central Lines:
Vents:	Vents:	Vents:	Vents:	Vents:	Vents:	Vents:
8	9	10	11	12	13	14
Foleys:	Foleys:	Foleys:	Foleys:	Foleys:	Foleys:	Foleys:
Central Lines:	Central Lines:	Central Lines:	Central Lines:	Central Lines:	Central Lines:	Central Lines:
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Central Lines:	Central Lines:	Central Lines:	Central Lines:	Central Lines:	Central Lines:	Central Lines:
Vents:	Vents:	Vents:	Vents:	Vents:	Vents:	Vents:
29	30	31				
Foleys:	Foleys:	Foleys:				
Central Lines:	Central Lines:	Central Lines:				
Vents:	Vents:	Vents:				

C-diff



Report that goes to Admin team and Governing Board
Monthly and Quarterly

Inpatient Infection Control Report

First Quarter 2011

Infection Control Summary for the Reporting Period

Infection Type	# of New Infections	Average Census	# of Days in Reporting Period	# of Patient/Foley Days per Reporting Period*	Infection Rate†
Health Care-Associated					
CAUTI					per 1,000 urinary catheter days (MS/ICU)
VAP					per 1,000 ventilator days (ICU)
CLABS					per 1,000 central line days (ICU)
Health Care-Associated (OTHER)**					
Community Acquired					

* The patient days per reporting period is calculated by multiplying the average census by the number of days in the reporting period. For example, if the average census is 100 and your reporting period is one week (i.e., 7 days) then the patient days per reporting period is: 100 x 7 = 700, or 700 patient days.

† The infection rate is the number of new infections divided by the number of patient days per reporting period x 1000. For example if your facility has 20 new infections and 700 patient days then the infection rate is: (20/700) x 1000 = 28.57.

** Patients admitted to CVRMC from other Health Care Facilities (CM, HHC, other hospitals)



GOAL FOR FUTURE

TARGET 0



"Quality, Efficiency, Compassion."

Challenges

- Keeping members and hospital staff informed and motivated about infection control issues
- Staff education on new Infection Control guidelines.
- Physician representation at Team Meetings

