The State of Infection Prevention: Yesterday, Today, Tomorrow

Presented by:
Kathleen Kohut, RN, MS, CIC, CNOR
Director of Infection Prevention
NCH Healthcare System

Speaker Disclosures

- Presentation sponsored by 3M
To Err Is Human: Building a Safer Health System
Institute of Medicine (IOM), November 1999
44,000-98,000 deaths due to medical errors annually
$17-20 billion per year

Patient Costs:
Lost income, household productivity, disability,
lack of trust in Healthcare System

Healthcare Industry:
Patient satisfaction, HCP morale & increased
frustration

Societal Costs:
Lost worker productivity ($$$), school attendance,
overall population health status

Called for a 50% reduction in medical errors.

To Err is Human – To Delay is Deadly
Published by the Consumers Union

Conclusions:
- Lack of data
- Est. 1,000,000 more lives lost
- Billions of more dollars wasted
- No nationally coordinated effort

Did We Achieve Our 50% Reduction?

- National Healthcare Quality Report (2009)
  - Perhaps worse rather than better
  - 1 in 7 Medicare pts experiences one or more adverse events
  - Thousands of CLABSIMs each year

AHRQ. Agency for Healthcare Research and Quality

Healthcare Research and Quality, Rockville, MD.
http://www.ahrq.gov/about/annrpt08
What Has Changed?

- Increase in demand for:
  - Quality care from consumers
  - Accountability from the legislators
  - Quality care from payors (CMS)
- Resulting in an increase in demand for data
  - State Collaboratives, SOWs, State HAI Plans, Legislation
- The catalyst:

Patients, Legislators, Payors

Public Reporting

HAI Reporting Laws and Regulations

- States with study laws
- States with public reporting of Medicare
- States with no reporting

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A Wake-up Call

- Oversight and Government Reform Committee’s Congressional Hearing
- Congressman Dan Burton (Indiana)
  - “if a nurse or a doctor doesn’t comply with the requirements, they ought to be penalized severely. Severely. Because people are dying because of that” (unofficial transcript, page 67).

http://oversight.house.gov/story.asp?id=1865

The Other Response

What Are IPs Doing About It?

- Bare minimum due to lack of resources, knowledge, experience and increased workloads
  - Ortho SSI problems with no surveillance
  - No time for data analysis
- Spending less time facilitating process improvements in order to crank out more data
  - Pennsylvania – 100% infection surveillance
  - Quality vs Quantity
- Reactive instead of proactive
Barriers to Progress in SSI Prevention

Lack of:
- Knowledge and experience in the OR
- Relationships & Collaboration
- Resources (people, time, money)
- Support from leadership

#1 Barrier is Current Culture

1. SSI is an unfortunate possibility
   (it says so right on the consent form)
2. The Business Case – maximization of OR volume to increase revenue
3. Tradition

1. Unfortunate Possibility

- We fail to believe:
  - That we are the cause of SSIs
  - That we can prevent SSIs
  - "My patients are the sickest"
- The surgeon that does the most volume has a greater risk of having an SSI
- Superficial SSIs are not even reported (i.e. important)
2. The Business Case

The focus on OR efficiencies has compromised the ability of the OR staff to perform basic SSI prevention

- Hand Hygiene
- Surgical hand scrubs (scrubbing and rubbing)
- Aseptic Technique
- Sterilization
- Cleaning

3. Tradition

The Sacred Cows

- The Surgeon is the “Captain of the Ship”
- Anesthesia Care Providers do not impact SSIs
- Skull Caps – a symptom of our illness

Ban Skull Caps

If it takes 17 years to adopt new technology, our time is up!

Surgical Conscience

- Requires strict adherence to the principles of aseptic technique by all team members for every patient on every case.
- ORs that value these principles create a patient-centered culture.


How Do We Get There?

The Joint Commission - NPSG.07.05.01

1. Educate – about SSI prevention strategies
2. Measure
   - Make regular observations of aseptic technique
   - Utilize data to implement change
2. Communicate
   - Provide the data to the HCP

Partner, Don’t Police

- IP mandating rather than partnering with the OR only brings resentment, not change
- Example:
  - Pulling alcohol-based surgical skin scrubs out of the OR
Why Not Report Patients instead of Rates?
Humanize the data

Total Knee SSI 1st Q CY 2007

Total Knee Patient Infections 1st Q CY 2007

Create a Vision

Story Telling
To keep the patient the focus

Messaging
To keep the task on focus

Leadership
To support the task

Strength
To endure the inevitable “noise of change”

Grady Memorial Hospital

First, We Must Believe in the Possibility of ZERO
ALL & NONE
Enabling NMB through knowledge, collaboration and leadership

Thank You