

Safety Goals

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required to provide education about infection control strategies to patients and families who are infected or colonized with multidrug-resistant organisms.

Hospitals will be required to have a surveillance program up and running by Jan. 1, 2010, that is based on the hospital's risk assessment. When indicated by the risk assessment, hospitals will need to implement a laboratory-based alert system to identify new patients with multidrug-resistant organisms, and an alert system to identify readmitted or transferred patients who have multidrug-resistant organisms.

The Joint Commission also has put new requirements in place to prevent central line-associated bloodstream infections and surgical site infections.

As part of the requirements related to central line-associated bloodstream infections, hospitals will be expected to use a catheter checklist and a standardized protocol for central venous catheter insertion and an all-inclusive standardized supply cart or kit for insertion of central venous catheters. The requirements also call for the use of standardized protocols for maximum sterile barrier precautions during insertion of a central venous catheter and when disinfecting catheter hubs and injection ports before accessing the ports.

As part of its effort to prevent surgical site infections, the Joint Commission is requiring hospitals to conduct periodic risk assessments, select surgical site infection measures based on evidence, and evaluate the effectiveness of their prevention efforts.

All of the new requirements related to health care-associated infections include a 1-year phase-in period, with milestones for planning, development, and testing throughout 2009.

Hospitals are likely to face some up-front costs when implementing the new requirements, especially if they need to put a new educational process in place to prepare

staff, said Dr. Franklin Michota, director of academic affairs for the department of hospital medicine at the Cleveland Clinic.

Hospitalists may be involved in developing process improvement plans, tracking requirements, or tracking infections. Those who are not involved on the quality side may be asked to champion changes at the floor level by modeling appropriate hand hygiene or compliance with contact precautions, Dr. Michota said.

The requirements for central line-associated bloodstream infections, in particular, are a significant step forward, said Dr. Patrick J. Cawley, president of the Society of Hospital Medicine and executive medical director at the Medical University of South Carolina, Charleston.

There is clear evidence in the literature that compliance with central line placement protocols can significantly drive down infection rates. "This is something we all should be doing anyway," Dr. Cawley said.

The Joint Commission also has added new requirements to the goal for medication reconciliation. Hospitals are advised to provide a complete and reconciled list of the patient's medications directly to the patient and explain the list at the time of discharge. In those settings where medications were used minimally or for a short duration, such as the emergency department, the hospital is required to perform a modified medication reconciliation process. For example, if a short-term course of an antibiotic is prescribed, the patient should be provided with a list containing the medications that the patient will continue using after leaving the hospital.

Also new in 2009 is a requirement to eliminate transfusion errors related to patient misidentification. Before beginning a blood or blood component transfusion, hospital staff must match the patient to the blood during a two-person bedside verification process. In cases where two individuals are not available, a bar code or other automated technology can be used in place of one of the individuals, according to the Joint Commission. ■

Hospital Targets, Reduces Central-Line Infection Rate

BY MARY ELLEN SCHNEIDER
New York Bureau

The physicians, nurses, and other clinical staffers at Tacoma (Wash.) General Hospital aren't sweating the new Joint Commission on Accreditation of Healthcare Organizations' requirements on central line-associated bloodstream infections that are scheduled to be phased in throughout 2009.

They have already implemented a central-line protocol that has brought their hospital's infection rate down to virtually zero over the last few years.

"Rather than accepting a certain rate of infections, we adopted the position that they should never happen," said Dr. James R. Taylor, medical director of the adult intensive care unit at Tacoma General Hospital and the hospital's physician champion on reducing central-line infections.

In 2005, he began educating physicians and nurses in his ICU about a bundle of measures for reducing central-line infections that he learned about as part of the TICU (Transformation of the ICU) project, a program from the national health care alliance VHA Inc.

Before implementing the central-line protocol, Tacoma General Hospital had an infection rate of about 1.5-2.0 infections per 1,000 central-line days, which was better than the national benchmark set by the Centers for Disease Control and Prevention. Since 2005, the hospital's central line-associated infection rate has been even lower. There were no infections in the adult ICU at Tacoma General Hospital for all of 2006 and 2007, said Marcia Patrick, R.N., director

of infection prevention and control for MultiCare Health System, which operates Tacoma General Hospital and three other hospitals in the area.

"It's a whole change in mind-set to zero tolerance," Ms. Patrick said.

Based on the success in the ICU, the hospital generalized the process to the emergency department, operating rooms, and anywhere else central-line placement was being performed.

The protocol is surprisingly simple, Dr. Taylor said. The main elements are proper hand hygiene, the use of chlorhexidine-based antiseptic for skin preparation, the use of a sterile drape to cover the whole patient, the placement of the line in those locations shown to have lower infection rates, and the removal of the catheter as soon as possible.

The key is to make it easy to follow the measures and difficult to do things the wrong way, Dr. Taylor said. For example, the hospital decided to remove from its line carts anything that might contribute to improper line placement, and to include only those materials that would aid in proper line placement.

Another element of the hospital's success has been empowering the nurses to speak up, Dr. Taylor said. Under the protocol, if a physician breaks sterile technique during the line placement, the nurses are required to step in and ask the physician to stop and start over. The hospital also created a checklist for the nurses to record that all the proper steps in the line placement were performed.

"It's pretty simple stuff, but when you do it in every line placement, the infections go away," Dr. Taylor said.

Infection Specialists Step Up Efforts to Control MRSA

BY HEIDI SPLETE
Senior Writer

During the past year, more than 75% of infection prevention and control professionals have taken extra steps to prevent transmission of methicillin-resistant *Staphylococcus aureus* in health care facilities, according to results of a survey conducted by the Association for Professionals in Infection Control and Epidemiology.

The nationwide survey was conducted in the wake of a 2007 report that showed a surprisingly high prevalence of MRSA in hospitals—eight times higher than previously estimated, said Janet E. Frain, R.N., president of the Association for Professionals in Infection Control and Epidemiology (APIC) and a certified professional in health care quality.

The poll results included data from 2,041 infection control professionals, representing 17% of the APIC's nearly 12,000 members. The results were presented last month in a teleconference.

Staff education was the most common new action among those who reported taking additional steps to prevent and control MRSA (64%). Other measures included stricter use of gowns and gloves for anyone who tests positive for MRSA (53%); improved compliance with house cleaning, equipment cleaning, and decontamination prac-

tices (49%); and targeted patient MRSA screening (49%).

But more than half of the survey respondents (54%) also reported that their institutions were not doing as much as they could or should to prevent and control MRSA.

"We are still seeing some infection control professionals struggling to get the support they need," said Kathy Warye, CEO of APIC. But the overall trend of the poll is encouraging, she said.

"We are talking about a complete culture change within the organization, where infection prevention and control is everyone's job," Ms. Frain said.

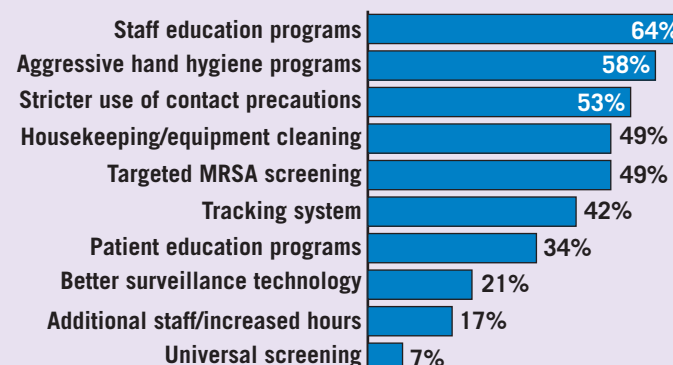
"I have a CEO who gets it," said Marcia Patrick, R.N., who serves as the infection control director for the MultiCare Health System in Tacoma, Wash. "In October 2008, Medicare will stop paying for things that shouldn't happen, such as urinary tract infections from Foley catheters. If hospitals aren't working on reducing these things, they are going to be in a world of hurt financially."

Successful infection control strategies that have been implemented at her facility include improving hand hygiene by installing alcohol gel dispensers in conve-

nient places, adding an infection control professional to the staff, and using data-mining software to review culture reports and identify infections quickly.

For more information about preventing infections, visit the APIC's Web site at www.apic.org, or their patient-oriented Web site, www.preventinfection.org. ■

Newly Implemented MRSA Interventions



Note: Based on a survey of 1,544 APIC members who adopted interventions.

Source: Association for Professionals in Infection Control and Epidemiology