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Infection Control is Everyone's Business

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Infection Control is Everyone's Business

The C4I initiative has placed a spotlight on patient and employee safety. Controlling the spread of infections is a critical component of every hospital safety program and an important cornerstone of our C4I initiative.

The Infection Control subgroup of C4I has identified four programs on which we will focus our efforts over the next three years. Although we may not eliminate all infections, we hope to limit the acquisition of nosocomial (hospital acquired) infections to an irreducible minimum.

Our target areas are the following:

- **Influenza immunizations**
- **Hand washing**
- **Surgical site infections**
- **Central venous catheter-associated bloodstream infections**

Influenza Immunizations

Our Influenza Immunization Program has three subprojects that target employees, high-risk outpatients, and hospitalized patients.

The goal of our Employee Influenza Immunization Program is to protect caregivers from influenza, to prevent absenteeism, and limit transmission of infection between patients and healthcare workers. Our ultimate goal is to “pursue perfection”—that is, we plan to identify and immunize all eligible healthcare workers involved in direct patient care by the next flu season.

Our Outpatient Immunization Program identifies patients cared for by our primary care practitioners who are at high risk for influ-

enza and who comprise our top tier of vaccine candidates. Having identified these candidates, we will ask our internal medicine doctors to contact them individually in order to emphasize their need for influenza immunization. We will keep accurate records of our success rate. Our goal is to immunize one hundred percent of these high-risk patients.

Our Inpatient Influenza Immunization Program will use automated orders through our electronic “POE” system to make sure that eligible inpatients have received, or will receive, influenza immunization prior to discharge. This program will be in effect from October through January. Our goal is to make sure that all eligible inpatients receive appropriate immunizations.

Members of the Influenza Work Group: Nancy Dupont, Richard Garibaldi, Lisa Jaser, Linda Shanley, Mark Metersky, and Marcia Trape-Cardoso.

Hand Washing

Hand washing has always been, and always will be, an important component of our infection control program. We have an ongoing campaign to improve hand washing in all clinical areas in the hospital and practice. We encourage personnel to wash their hands with disinfectant solution or at a sink before and after every patient contact. We have installed hygienic hand rub solutions in strategic clinical areas to facilitate good hand hygiene.

Our C4I project on hand washing will attempt to determine how effective our education programs are in improving hand washing practices among employees. We have met with infec-

tion control personnel from other hospitals to learn more about their programs and will introduce some of these techniques in selected units at JDH. Our goal is to monitor compliance to the CDC's guidelines for appropriate hand washing and to compare different classifications of healthcare providers to see which group does best. We would like to see decreases in the rates of acquisition of hospital-acquired infections that are spread from one patient to another on the hands of personnel.

*Members of our Hand-Washing Task Force:
Janine Childree, Joseph Civetta, Nancy Dupont, Holly Florio,
Richard Garibaldi, John Kennelly, Mary Kinahan, and
Marie Sudsbury.*



Hand cleanliness is THE most important technique to prevent the transfer of nosocomial organisms from one patient to another by eliminating hand carriage of pathogenic bacteria by staff.

Surgical Site Infections

A desirable outcome for any infection control program is to reduce the incidence of surgical site infections to an irreducible minimum. This is a complex process that requires the cooperation of many different caregivers as patients move from the outpatient practice, through pre-operative preparation, to the OR and recovery room, and finally to a hospital bed and home.

The Surgical Site Infection Task Force has focused on one specific practice in this process that greatly impacts the likelihood of subsequent infection: the timing of perioperative antibiotics. There is excellent medical evidence to suggest that perioperative antibiotics should be administered from zero to sixty minutes prior to the procedure. Infection rates increase in surgeries in which perioperative prophylaxis is given outside this zone.

Calculating the timing of perioperative antibiotics in relation to the time of surgical incision has proven to be a formidable task. We have now been able to merge different electronic information systems in order to enable us to make this calculation. Compliance with proper timing guidelines should result in lower rates of surgical site infections. Over time, we should generate enough data to determine whether or not this premise is true.

*Members of our Surgical Site Infections Task Force:
Joseph Civetta, Nancy Dupont, Richard Garibaldi,
Karen Livingston, Denise Mazzamurro, Mark Metersky,
Anthony Peluso, Carol Schramm and Linda Shanley.*

Central Venous Catheter-Associated Bloodstream Infections

Although it is relatively easy to collect information about central venous catheter bloodstream infections, it is extremely difficult to collect data that enables us to calculate rates of infection in catheter days. Presently, we have no system in place to collect information concerning at-risk days, even in a well-defined unit such as the Medical Intensive Care Unit. The first task of this work group is to set up an electronic data-collection system that will enable us to identify the exact number of days each patient in the ICU is being treated with a central venous catheter. We will then identify catheter-associated bloodstream infections in these patients and compare our rates with benchmark data from the CDC's National Nosocomial Infection Study (NNIS).

In the meantime, we have made changes in the disinfectant used to prepare the catheter site, the safety equipment used for catheter insertion, and catheter site dressing protocols. We hope that we will be able to calculate rates of bloodstream infection that are accurate enough to enable us to determine the impact of changes such as these on infection rates.

Members of the Central Venous Catheter-Associated Bloodstream Infection Taskforce: Scott Allen, John Casey, Joseph Civetta, Kathleen Coyne, Nancy Dupont, Richard Garibaldi, Heather Gifford, Julie LaFlamme, Linda Manzelli, Mark Metersky, and Linda Shanley.

Patient Safety Is Everybody's Business

Through the C4I initiative, we hope to collect data that will document how good, or how bad, we are in protecting our patients and our employees. This is just a start, but a very important start if we are to become one of the safest hospitals in the nation.

*Richard A. Garibaldi, M.D.
Professor and Chair, Department of Medicine
Hospital Epidemiologist*

REMEMBER THESE SIMPLE TIPS TO PREVENT THE SPREAD OF INFECTIONS IN THE HOSPITAL:

- **Wash your hands after all direct patient contacts.**
- **Wash your hands if they become soiled.**
- **Wash your hands, wash your hands, wash your hands.**
- **All patients are potentially infectious.**
- **Your hands are the most likely vehicle by which bacteria are carried from one patient to another.**
- **Get your flu shot this year.**
- **Pay attention to detail—make sure your patients get their medicines and treatments on time.**
- **Be careful...especially when working with needles and other sharp objects.**