

Reset and Recharge



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Staphylococcus Aureus



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Current State

Nationally, significant increases in 2020 were observed for CLABSI, CAUTI, VAE, and MRSA bacteremia compared to 2019. The largest increases occurred during quarter 4 2020. Note: 1. "No change" signifies that the change in SIR was not statistically significant."

	2020 Q1	2020 Q2	2020 Q3	2020 Q4
CLABSI	↓ -11.8%	↑ 27.9%	↑ 46.4%	↑ 47.0%
CAUTI	↓ -21.3%	No Change <sup>1</sup>	↑ 12.7%	↑ 18.8%
VAE	↑ 11.3%	↑ 33.7%	↑ 29.0%	↑ 44.8%
SSI: Colon surgery	↓ -9.1%	No Change <sup>1</sup>	↓ -6.9%	↓ -8.3%
SSI: Abdominal hysterectomy	↓ -16.0%	No Change <sup>1</sup>	No Change <sup>1</sup>	↓ -13.1%
Laboratory-identified MRSA bacteremia	↓ -7.2%	↑ 12.2%	↑ 22.5%	↑ 33.8%
Laboratory-identified CDI	↓ -17.5%	↓ -10.3%	↓ -8.8%	↓ -5.5%

Werner Ladhagen, L. Patelbaraman, V. Karmali, A. Patel, P. Wong, E. Wu, S., Dandekar, M. (2021). The impact of coronavirus disease 2019 (COVID-19) on healthcare-associated infections in 2020: A summary of data reported to the National Healthcare Safety Network. Infection Control & Hospital Epidemiology, 43(1), 12-25. doi:10.1017/ica.2021.362

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Diseases and Organisms found in Healthcare Settings

- Acinetobacter
- Burkholderia cepacia
- Candida auris
- Clostridioides difficile
- Clostridium Sordellii
- Enterobacteriales (carbapenem-resistance)
- ESBL-producing Enterobacteriales
- Gram-negative bacteria
- Hepatitis
- Human Immunodeficiency Virus (HIV/AIDS)
- Influenza
- Klebsiella
- Methicillin-resistant Staphylococcus aureus (MRSA)
- Nontuberculous Mycobacteria (NTM)
- Norovirus
- Pseudomonas aeruginosa
- SARS-CoV-2
- Staphylococcus aureus
- Tuberculosis (TB)
- Vancomycin-intermediate Staphylococcus aureus and Vancomycin-resistant Staphylococcus aureus
- Vancomycin-resistant Enterococci (VRE)

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There are several causes of healthcare-acquired infections, including the following:

- Unsterile surgical or procedure tools
- Antimicrobial resistance (AR)
- Improper handwashing techniques
- Improper use of PPE
- Increased number of patients being seen in clinical settings
- HVAC filtration system issues
- Contaminated surfaces because of improper cleaning
- Workflow and design

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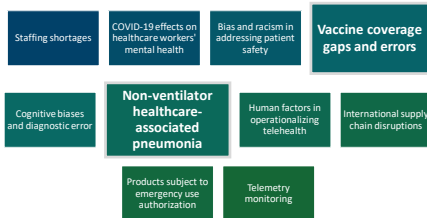
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ECRI's Top 10 Patient Safety Concerns 2022



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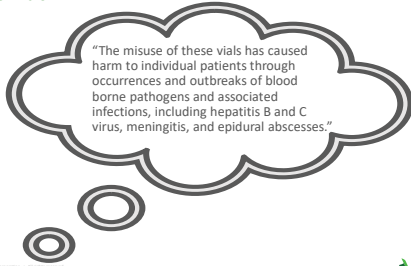
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**The Joint Commission Sentinel Alert 52; preventing infection from the misuse of vials**



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**Sepsis misdiagnosis in a hospitalized post-operative patient**

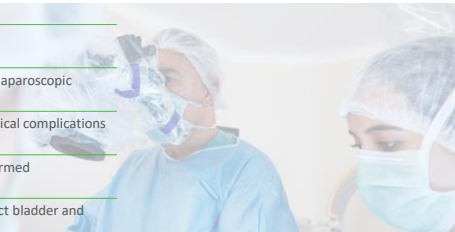
75-year-old male

Robotic-assisted laparoscopic prostatectomy

No apparent surgical complications

Cystoscopy performed

Observed an intact bladder and patent ureters



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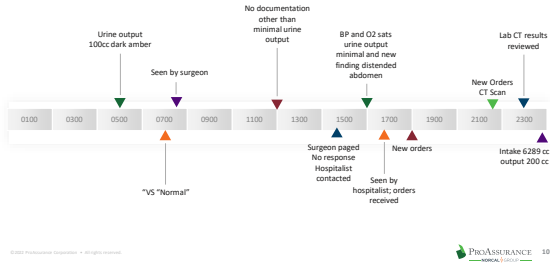
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### Post Op Day 1



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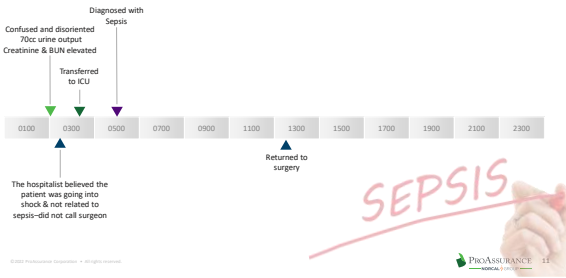
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### Post Op Day 2



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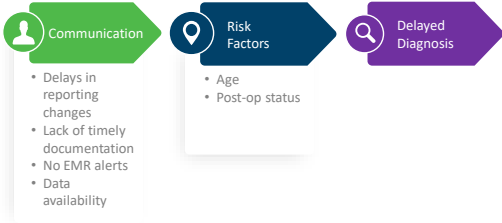
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### Discussion



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**As the case unfolded**

**Experts**

- Unsupportive
- Lack of communication

**Causation**

- Delay in diagnosis

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**Risk Reduction Strategies for Leadership**

- \_\_\_\_\_
- Raise sepsis awareness
- \_\_\_\_\_
- Coordinate sepsis teams
- \_\_\_\_\_
- Implement protocols for early detection and response
- \_\_\_\_\_
- Empower staff
- \_\_\_\_\_
- Use data to drive improvement

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**Risk Reduction Strategies for the Healthcare Team**

- \_\_\_\_\_
- Document per facility policy
- \_\_\_\_\_
- Use screening tools
- \_\_\_\_\_
- Communicate sepsis risk
- \_\_\_\_\_
- Have a standardized process in place
- \_\_\_\_\_
- Have a plan to initiate treatment
- \_\_\_\_\_
- Utilize a Chain of Command

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**Outpatient settings**



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**Case scenarios**

- Flu Vaccines in Peds Office
- Reusing single use items in an infusion clinic
- Reusing insulin pens
- Multi-use glucose monitors



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**Discussion**

- Oversight
- Knowledge Gap
- Training
- Competencies

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Discussion



Standardized Processes



Quality Improvement and Control



Self-assessment

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Handwritten notes area with horizontal lines.

Risk Reduction Strategies for the Healthcare Team

Ensure proper supervision and oversight

Assess initial and ongoing skills competency

Provide training when necessary

Educate staff about documentation principles

Keep training and competencies records



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Handwritten notes area with horizontal lines.

Risk Reduction Strategies Infection Prevention

Adhere to local, state, and federal requirements

Perform regular audits for quality control and improvement

Ensure a notification process is in place

Keep maintenance records and operations logs for confirmation of the sterilization process.

Establish policies and procedures for routine cleaning and disinfection



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### Culture of Safety and Process Improvement

- Show Respect
- Speak up
- Report mistakes
- Listen to concerns
- View errors as opportunities for improvement



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### Just Culture Principles

**HUMAN ERROR**

- Inadvertent
- Support

**AT-RISK BEHAVIOR**

- Conscious choice
- Counsel

**RECKLESS BEHAVIOR**

- Conscious disregard
- Disciplinary action

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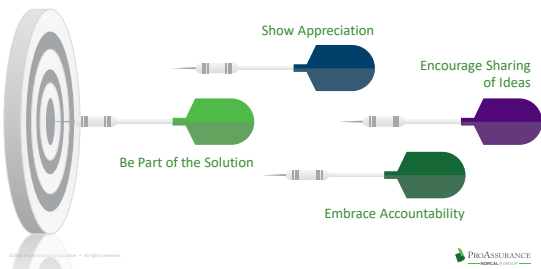
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### Successful Process Improvement



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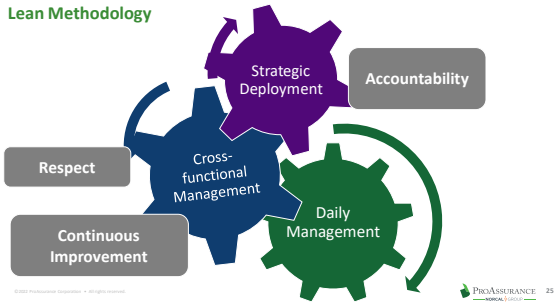
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Lean Methodology



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Describing Lean

- Leadership
- Eliminate Waste
- Act Now
- Never-End



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Continuous Improvement



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Lean Tools and Techniques

- 5 S
- 5 Whys
- Kaizen
- A3 project
- 8 Wastes
- Standardized Work
- Value Stream Mapping
- Spaghetti Diagramming



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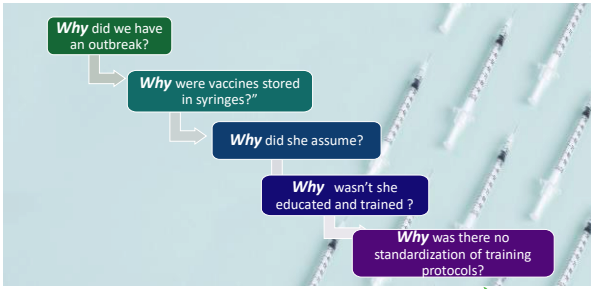
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Intervention Characteristics



There are challenges to implementing standardization

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Process of Implementation



Engaging frontline employees in developing Lean redesigns is a *critical step*

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A learning culture is constantly improving and oriented toward a common goal...

Patient Safety



Chickloayen PG 2nd. Just culture: a foundation for balanced accountability and patient safety. *Ochsner J.* 2013;13(3):400-406.

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