

Hospital response to CR's questions

Floyd Memorial Hospital and Health Services

1) Are there specific reasons that your infection rates were higher than average during the time period of Oct 2013- Sept 2014?

Mid-year 2013, Floyd Memorial's method of testing for detection of CDI was changed from EIA (Enzyme Immuno Assay) alone to EIA with the addition of the Nucleic Acid Amplification Test (NAAT). This coincides with our increase in detection of organisms in the facility due to the increased sensitivity of this testing method. Molecular assays are more sensitive than the traditional methods of non-molecular testing, allowing us to identify more cases than if we were using EIA alone; therefore, resulting in better treatment for patients by earlier and more accurate testing.

Many hospitals do not use the EIA with NAAT because of the additional expense related to this testing method. Floyd Memorial chose to run this test, in spite of the additional cost, to provide better care for our patients.

When we changed mid-year 2013 to the higher sensitivity test, we were still being compared to the previous group of hospitals utilizing the less sensitive method. The reporting system to CMS did not offer the opportunity to report testing methods monthly. In 2015, the reporting plan changed, and now, requires you list your method of testing monthly because there is a difference in sensitivity and specificity of the methods.

2) Do you have an antibiotic stewardship program?

Yes, we had already initiated the Antimicrobial Stewardship program to assist in the more appropriate use of antibiotics, and in 2014, we initiated the Scrub the Hub Campaign. In addition, we identified the need for an overall enhanced infection prevention process, therefore:

- o We increased the number of Infection Preventionists to enable us to better identify and follow up on appropriate measures.
- o Completed a lengthy investigation and concluded the increase in CDI was a result of the new testing.
 - Concluded that MRSA was elevated in 2013 and the first half of 2014. Therefore, during the summer of 2014, we initiated a Scrub-the-Hub Campaign, and in September of 2014, we enhanced our emphasis on isolation precautions. Since that time, we have nearly eliminated MRSA bacteremia that was a hospital acquired infection (HAI).
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3) Do you have a specific program on infection control?

Yes, our infection control plan addresses all areas of potential risk, both inpatient and outpatient, at Floyd Memorial Hospital. This is accomplished through the multidisciplinary risk assessment. Performance of this risk assessment identifies hospital specific and community-based factors requiring focused intervention.

The facility infection prevention risk assessment is a process that requires multidisciplinary input and organizational support. The risk assessment is the basis for the infection prevention program and provides clarity in departmental and organizational activities, outlines where resources are to be largely focused and frames the program report.

This assessment is a collective work by all whose responsibilities impact the infection prevention program. Members of the multidisciplinary team include:

- Infection Prevention
- Infectious Disease Physician
- Microbiology
- Pharmacy
- Emergency Preparedness Coordinator
- Environmental Services
- Medical Staff
- Administration
- Community Health Nurse
- Nursing Services
- Surgical Services
- Respiratory Care Services
- Infusion Services (IV Team)
- Facility Engineering
- Food and Nutrition Services
- County Health Department

The Centers for Disease Control and Prevention (CDC) recommends one Infection Preventionist for hospitals with average daily census of 115 patients (Published in the American Journal of Infection Control 2001). Similarly, APIC text cites an acute care with 200 bed facility staffing at 1.6 IP FTE's (APIC text 2014). Therefore, in 2013, we added a second Infection Preventionist to our staff for a total of 2.0 FTE's, a recommendation of the Association for Professionals in Infection Control and Epidemiology (APIC). This has allowed a more proactive approach by providing education and support for our associates. This also allowed for more surveillance of the facilities, review of staff practices and identification of infections.

For accountability and tracking, we monitor through the review of labs, hand washing audits, isolation audits, multidisciplinary rounding and physician infection disclosure. Information attained during this monitoring is reported to Nursing Leadership, at the Infection Control Committee, the Medical Care Committee, the Medical Executive Committee and the Board Quality meetings as part of the plan.

4) Have you made any changes since the period covered in the ratings?

Yes, as stated in a previous response:

- o We increased the number of Infection Preventionists to enable us to better identify and follow up on appropriate measures.
- o An Antimicrobial Stewardship program was enhanced in 2013 to assist in a more appropriate use of antibiotics.

- o We initiated a Scrub-the-Hub Campaign in 2014, and in September of 2014, we enhanced our emphasis on isolation precautions. Since that time, we have nearly eliminated MRSA bacteremia that was a hospital acquired infection (HAI).
- o During this time we also revamped our isolation signage and education using the ISO signs that are a permanent part of the room.
- o Through our Picture Perfect Program, we focused on the training and auditing of room cleaning practices. This includes using a bioluminescent marker to visualize if the room has been cleaned properly. We also provided additional education to the Environmental Services Staff on the daily and terminal cleaning of rooms that included proper contact time of the disinfectant to allow for proper kill of organisms.

5) Do you have any additional comments?

After the change in testing method, we identified opportunities for improvement, acted upon those opportunities and improved our overall program. The results included:

- Compliance with personal protective equipment (PPE) and isolation precautions increased greatly and has been maintained.
- Surveillance rounds are done twice weekly, and individual correction and education are done as needed.
- Since that initial period, we have nearly eliminated MRSA bloodstream infections.