Implementing Infection Control
Ways to get your hospital to talk about infection control

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Hosted by Paul Webber
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Healthcare anno 2018
...all about benjamins
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ECDC Core Competencies

- Programme management
- Quality improvement
- Surveillance and investigation HAI
- Infection control activities

Generating money or convincing administrators is nowhere in it

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Still forced to run an IPC program, but luckily no law on how much I have to invest into it
_except suggestions with regard to the FTE for IPC nurses_

Reduced incidence of HAIs – saves costs for “the society”
_but what’s it to my hospital? Certainly not a revenue-generator._

Two questions to answer

_#1 What can I do to convince my hospital director?_

_#2 What do I have to ask my hospital director?_
What can I do to convince my hospital director?

1. Convince your administration that "we" have a problem
2. The "business case for IPC"
3. Ensure your "mission" is known
4. Show that IPC is more than "saving costs"
5. Choose best things to do with your "fixed budget"
6. Never waste a good outbreak or public health crisis

1. Convince your administration that "we" have a problem

Show that HAIs are a problem in your hospital

- First prevalence study of NI at HUG, 1994
  - Prevalence of infected patients: 16.9%
  - Total number of admissions: 40,000 (~6800 infected)
  - Additional costs associated with treatments, complications, and increased length of stay (estimates, CHF): 23.5 mio

Do we have a real problem?
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Houston we have a problem

Make sure that Houston (=hospital administration) knows that “we” includes them: They have a problem!

IPC not the problem holder, but …

... the prevent and repair team
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2. The Business Case For Infection Control

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The business case for ICP (SHEA guideline)

1. Frame the problem + create hypothesis about solutions
2. Create interest by meeting with key stakeholders
3. Determine local costs of intervention, costs that can be avoided by reducing HAI, and attributable and variable costs
4. Calculate financial impact and other health benefits
5. Communicate the possibilities of the BC
6. Prospectively collect cost and outcome data

My personal view on business cases

a well thought of and non-detectable sum of lies and assumptions to be able to finance what we believe is needed

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### Truly and accurately evaluate the cost-benefit

- Describe a problem (e.g. CLABSI)
- Look for possible solution (e.g. coated catheters vs “bundle”)
- Do a full economic evaluation estimating the costs of CLABSI in your hospital (including extra LOS) and the costs of the intervention
  - Benefit is reduction of costs AND gain of revenue (e.g. shorter LOS)
- First use basic IPC – than start on the “gadgets”

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### Be proactive with regard to BC’s

Do not wait until a typical doctor in your hospital wants to implement a new gadget based on alternative facts, or on arguments

“...This is so great, so much better”

such as ...
3. Ensure your “mission” is known

Sounds un-needed?

People (including the Medical Director) will follow you much easier if they know what you stand for

Example of “mission statement”

Our mission is to promote a healthy and safe environment by preventing the spread of MDROs and the transmission of infectious agents among patients and staff.

We strive to accomplish this in an efficient and cost effective manner, based on external and internal standards, keeping in mind the best ways we can support our clinical colleagues and serve our patients and their families.

adapted from Hoffmann K, Infect Control Today, Dec 2000
4. Show that IPC is more than “saving costs”

Cost-effectiveness is not the only key to your administrator’s heart...

- Safe care = better care
- Corner-stone in preserving antibiotics
- Stimulate general preventive measures e.g. flu-shot
- Engage in visible actions e.g. hand hygiene action that get picked-up by press
- Educate not only HCWs, but patients and the public
- Try to evaluate patients satisfaction with regard to IPC
4. Never waist a good outbreak

This is the time to put all your knowledge and engagement into visible action

- the better you do your job normally, the less your work is recognized

Time to stress the importance of new typing methods, rapid diagnostic test or an IPC measure that so far weren’t funded

- VRE outbreak: cleaning wipes
- Flu-threat: GeneXpert and others
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What are you asking for?

[Image of a car]

What are you asking for?

[Image of an island]

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5. Choose best things to do with your “fixed budget”

- Task differentiation
- Link-nurse system
- Prioritize high prevalence units/problems
  - actually choose “posteriorities” you really don’t do!
  - turf unwanted tasks (e.g. needle-stick accidents to occupational health)
  - invent new positions in professional guidelines (DSMH/DSRD)
- Invest in better software and automation (e.g. surveillance)
- Engage clinicians (e.g. surgeons in charge of SSI improvement)

What do I have to ask my hospital director?

1. Structure and position in organization
2. Access to all data sources
3. Use of rapid diagnostic tests & typing
4. Moral support (by administration and medical director)
5. Finance CME including (non-ICP) education
6. Freedom and support to implement new idea’s
1. Structure and position in organization

- Independent department
- Direct line with administration
- Referred responsibilities for ICP
- ICT support & software
- Located within hospital, preferably in conjunction with MMB or ID-service
- A better than SENIC formation

Infection Control-team
(SENIC guideline)

1 MD per 1000 beds  1 ICP per 250 beds
Infection Control-team
(in real life)

“Use whatever you got”

Infection Control-team
(as it should be)

1 ICP per 5000 admissions, 1 IC-MD per 25000 admissions

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2. Access to all data sources

Access to:

- All departments (requested and un-requested)
- All patient files
- OR systems
- Complication registration systems
- Census data of the hospital
- Facility services and medical technique reports

3. Access to rapid diagnostics & typing

Rapid detection = 1st step of control

This is what I talk about ...

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POCT & zero-costs diagnostics

- Testing in all healthcare settings
  - today mainly hospital
- Direct action with regard to “isolation”
  - less transmission, better logistics
- Change of empiric treatment
  - as a consequence reduction of mortality
- Paradigm shift in LMI-countries
  - from no diagnostics to the top

4. Moral support

- Administration and medical director (or executive board of the medical staff) need to be main and visible drivers of the patient safety culture change

- Without their support no major changes in your institution will be achievable
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Certainly true with regard to Infection Control.
5. Support CICE including (non-ICP) education

- Continuous Infection Control Education (CICE) for ICPs is a must
- Invest in “soft” education such as communication skills, behavioral science, negotiation skills, ...
- Make in-house ICP education mandatory (min. starting HCWs)
- IC-meetings for regional stakeholders (and the general public)
- Include ICP training early-on in training of nurses and interns (preferably at school level)

6. Freedom to implement new idea’s

RETHINK
Basics Are The New Black

- Behavior
- Patient participation
- Transmission prevention
  - Hand hygiene, environmental control
- Surveillance
- Guidelines
What is a Surgical Site Infection (SSI)?
Surgical site infections (SSIs) are wound infections that occur after invasive surgical procedure at the body part where surgery has been performed. These infections may involve only the skin, or may be more serious and involve tissue under the skin or organs. A surgical site infection may cause symptoms such as: redness, warmth, pain or tenderness around the affected site, drainage of pus or fever. The majority of SSIs become apparent within 30 days from the surgical procedure.

What are hospitals doing to prevent the occurrence of surgical site infections?
Hospitals perform surgical site surveillance for specific operations and can then compare to national levels. As part of the preoperative process, for cardiothoracic, orthopaedic or other high risk surgery you will be screened for Staphylococcus aureus carriage (a nasal swab will be collected). If you are a carrier of Staphylococcus aureus you will need to adhere to treatment with an ointment and possibly an antiseptic wash for the recommended duration before and after your surgery.

What can I do to prevent Surgical site infections?
Before the surgery:
- Smoking is a known risk factor associated with complications during and also after the surgical procedure. People who smoke are prone to developing more infections after surgery. It is recommended that you stop smoking 4 weeks or longer before your surgery. Your healthcare provider should be informed of the following:
  - Your medical history, particularly in case of diabetes mellitus.
  - Your travel history within the last year or previous recent hospitalisation abroad.
Another basic - long ignored (in the NL)

Hospital Cleaning

[Image of a woman mopping]

Modern cleaning

HPV

UV

[Images of cleaning equipment]

 +/- special wall paint

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Modern cleaning

Bed cleaning robot

Modern (continuous) cleaning

Copper is here already – other (nano)technology will come

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The feedback of structure-, process- and outcome parameters to HCWs will continue to be an important part of infection control.

Surveillance only works when going “full-circle” (PDCA).

Bundles, including bundle compliance, should be included in surveillance systems.

Not the need for surveillance but the methods will change.

Fully-automated surveillance using AI

Right algorithm & possibly changed definitions
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Far too many guidelines – not enough common sense

Truck = healthcare quality system

Thanks a lot

My own experience with hospital directors

not stopping me from doing something, but giving me a push!

(even it it sometimes took a while for them to recognize that should be their job)

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(FREE...WHO Teleclass - Europe)
NEW PERSPECTIVES ON INFECTION PREVENTION AND CONTROL PROGRAM
ASSESSMENTS IN THE SPIRIT OF IMPROVEMENT
December 14, 2018
Speaker: Prof. Benedetta Allegranzi, World Health Association Global Infection
Prevention and Control Unit
Sponsored by the World Health Association

(FREE European Teleclass)
THE FALLOUT OF FAKE NEWS IN INFECTION PREVENTION, AND WHY
CONTEXT MATTERS
January 17, 2019
Speaker: Prof. Didier Pittet, University of Geneva Hospitals, and Dr. Pierre
Parneix, Hôpital Pellegrin, CHU de Bordeaux, France

BARRIERS AND FACILITATORS TO CLOSTRIDIUM DIFFICILE INFECTION
PREVENTION, A NURSING PERSPECTIVE
January 31, 2019
Speaker: Dr. Nasia Safdar, University of Wisconsin School of Medicine and Public

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