Eve:	Appropriate catheter utilization. Advance to the next slide. My [inaudible 00:00:17] cast lead for the reducing [inaudible 00:00:21] and hospitals task. With me are some of the Quality Insights staff, and [inaudible 00:00:30] picture on the next screen, as soon as I can get there. Advance [inaudible 00:00:41].
Speaker 2:	...That be showing with the pictures. You have center of capabilities. Go ahead [inaudible 00:00:51] advancing.
Eve:	Go to the next slide, please ... Sharing with us. As I said, I'm here with some of the Quality Insights staff and guest speakers from Pennsylvania. I will introduce ... From [inaudible 00:01:12] and Delaware Hospitals, I'm sorry. I will introduce our guest speakers in a few moments. The [EI 00:01:18] team members that are presenting today include Heather Banker, Jane Earhart, Debbie Fasenton, and Ronnie Summers. Advance the slides for me, they're not advancing.
Speaker 2:	[inaudible 00:01:42]
Eve:	They're saying. [inaudible 00:01:55]. I guess I'm just not seeing them. Before we begin, I'm sorry, you all, thanks for bearing with us. Before we begin discussing urinary catheter utilization, I would like to do a brief overview of the Quality Insights Quality Innovation Network. Quality Insights is one of the 14 quality-based networks or QINs. We are comprised of 5 states. The [inaudible 00:02:19] QINs for these states are all working together as the Quality Insights, Quality Innovation Network. 5 states represent gold on the map, are Delaware, Louisiana, New Jersey, Pennsylvania, and West Virginia. Next slide please.
	Quality Insights will focus on 4 [HAIs 00:02:39] as part of the reducing health care associated infections and hospitals task. [inaudible 00:02:46] associated bloodstream infections or [inaudible 00:02:50] associated urinary tract infections, or [inaudible 00:02:53] infections, or CDI, and ten your associated events, or VAE. You may choose to participate in the HAI project and focus on the HAI or HAIs that are of most concern to your hospital. We encourage you to begin projects by focusing on one or more units, then spreading evidence-based strategies hospital wide. Some of you that are listening have signed agreements and are part of our collaborative, or what [inaudible 00:03:20] our Learning in Action Network, or LAN. If you have not signed an agreement or you're not sure if you're participating, then please contact us. We will be soon closing recruitment for the project.
	The next slide, please. Here we are focusing on CAUTI and urinary catheter utilization. Objectives for today's presentation are to identify best practices for appropriate urinary catheter utilization, identify at least one or 2 points from the hospital presentations that can be applied in your hospital, and understand the benefits of targeted assessment for Targeted Assessment for Prevention, or TAP.

Turn the presentation over to Jane Earhart from Louisiana. Jane will share some urinary catheter best practices. Jane?

Jane: [inaudible 00:04:09]. We're happy to have you with us today. Let's look at CAUTIs and urinary catheter utilization. A key to reducing CAUTIs is decreasing the culprit of the infection, namely, the urinary catheter. I'm sure you've all read and heard that many times, urinary catheters are inserted inappropriately, or urinary catheters continue too long, or are even overlooked. [inaudible 00:04:34] catheter risks not always appreciated, and culture change is most important, but difficult to achieve. Unnecessary urinary catheter insertion often becomes a chronic disease, and the mortality rate associated with CAUTI is very high, and can cause physical as well as emotional harm that lasts a long time.

Questions we need to ask. Are we doing the basics? Do we [inaudible 00:05:00] change and end the CAUTI trend? Do we have the teams in place? Here are strategies to decrease innapropriate urinary catheter use. Number one, utilization protocol for appropriate urinary catheter indication. [inaudible 00:05:16] processes throughout the hospital that give your front-line staff the ability to succeed and be excellent at the jobs, not processes that are cumbersome and lead to inevitable failure. All our employees want to do their best, and do good care for their patients. 2, identify high urinary catheter utilization units. Get those specific units with intervention efforts. Use observed competency in areas where catheters are inserted. These are great opportunities for instruction.

You [could 00:05:53] possibly develop RNs to help study catheter insertion instruction video that RNs can [inaudible 00:06:02] as often as they need to. 3, implement a nurse driven urinary catheter removal protocol [inaudible 00:06:10] daily, or better yet, each shift, using a checklist for reviewing the necessity of the urinary catheter continuation for patients with catheters. [inaudible 00:06:20] point engaged and trained unit champions to drive changes at the point of care, and meet with them monthly to discuss your efforts, your successes, and any continuing need for improvement.

Last but not least, always show appreciation for their personal commitment. Above all, [inaudible 00:06:41] alone. [inaudible 00:06:43] often to keep momentum going, sustain the changes, and keep the whole facility informed about your effort. Now, back to Eve.

Eve: Thanks, Jane. We're honored to have 2 guest speakers with us today. We're going to have a short Q&A session after the 2 guest speakers and before we start the session on CAP reports. Please enter your questions into the chat or the Q&A box over to the right of your screen, and then we'll read those and answer them during the Q&A time. Getting to load the next set of slides, and these will be

with Andrea Andrews. We are most pleased to introduce Andrea Andrews. Andrea is the director of quality and case management at Lehigh Valley Hospital in Hazelton, Pennsylvania, for the past 30 years. Andrea oversees quality and case management functions within her facility, along with infection control and patients' safety. She's also the stroke coordinator at her hospital. Andrea?

Andrea: [inaudible 00:08:00]

Eve: I don't see your slides either. Christy, can we load ... Okay. Andrea, go ahead.

Andrea: Thank you for the introduction, Eve. We are 150 bed acute care facility hospital. A community hospital, but we're not that small, we're 150 beds. We [inaudible 00:08:23]

Eve: [inaudible 00:08:28]

Andrea: Northeast Pennsylvania. [inaudible 00:08:41] the mountain areas. Like I said, 150 beds. We are not only a small community hospital, we don't feel that way anymore. We feel even though 150 beds, it's a nice number that we can join in projects and show improvement and working better at what we do. We work Hazelton General Hospital, part of Greater Hazelton Health Alliance until January 1st last year when we merged with Le Valley Health Network, and we're really proud to be a part of this network with Seacrest and Mulenberg and their other campuses. We feel that we can really join force with a larger network [inaudible 00:09:22] within our community hospital and help each other. Next slide [inaudible 00:09:31] emergency room.

            We decided to look at urinary catheter use in the emergency room, and we identified the ED as one of the places where we had most of our Foley catheters inserted, and we didn't understand why. We looked at the reasoning why we might be doing this. We were [inaudible 00:09:52], but we couldn't say why. Nobody had a definite reason. We asked nurses, the manager, nobody could give a definitive reason why you were doing it. Many times the Foley catheter was inserted in the ED, but was never removed prior to the patient going from the ED to nursing unit. There was no reason to even put in the first place, so why should I [inaudible 00:10:14] ED to the acute care site with the Foley still in.

            [inaudible 00:10:20] the criteria for appropriate catheter usage in the ED, or even on the [inaudible 00:10:24] unit. Ultimately, we figured what happens in ED impacts the catheter use because it was just started there, but it continued to stay throughout the stay in hospitalization. Next slide. Our to-do was ... We were lucky to be part of an initiative called the accelerating best care program that our state legislature, back in 2006, got the hospital involved with on east. Meadville was the hospital on the west. We were trained by professionals from Bailer

University and Jefferson University in how to accelerate best care and the process for our patients where you look at rapid cycle interventions. One piece of the puzzle. You pick the hospital or unit to focus on. We try to fix stuff, the whole picture, the whole puzzle, you find that you fail.

You have to take one piece of the puzzle at a time. What we did was we implemented our accelerating best care performance initiative team. We did tat CAUTI team and had multi-disciplinary staff members who worked with the patients day-in day-out. What we found out through the accelerating best care process was you need to have [inaudible 00:11:39] staff who are engaged in this process and want to see things get better. Many times, we found out that going to the department or managers was great, but the staff is working with it day-in day-out. They're in the trenches every day working with these patients, and what they had to offer was really important.

They were involved. They helped us develop criteria for Foley catheter insertion. We mentioned the ED first. This process taught us to begin with one piece of the puzzle at a time. Next slide. Urinary catheter insertion, we devlop criteria and we [inaudible 00:12:16] buying it from our GU and GYN physicians. [I don't know 00:12:19] in other hospitals, in our hospital, a [inaudible 00:12:22] staff is really engaged in working with us and doing what needs to be done if they are a part of the process. We find it much easier to get the medical staff buying it if they had a say in the criteria itself. GU and GYN physicians were very important. The gave us their buy in. They did have suggestions for us we incorporated into our catheter criteria. We [inaudible 00:12:46] electronic health record. We have a hard copy policy, but we [dipped 00:12:51] into our electronic health record and made it so that we use Meditech that this criteria could not be bypassed.

Any time you file through the Meditech system with some [inaudible 00:13:01] that were built, people bypass the process. We would not let them do that with this situation. [inaudible 00:13:08] catheter use every day, [inaudible 00:13:12] why the catheter could not be removed, use the continuation criteria to ensure there was a valid reason for the catheter not being removed. [inaudible 00:13:21] catheter removal criteria, we had [inaudible 00:13:24] protocols put in place. This was not easy, but it was implemented because we figured [inaudible 00:13:30] you need an immunization, you don't need an order for that. You have protocols. We developed the same process here with Foley catheters. The nurse-driven protocol was implemented, the catheter was removed, and the only time a Foley catheter was continued if they met continuation criteria and we needed that physician order in order for that Foley catheter to stay in place. Next slide.

It might be a little bit difficult to see, but this is the criteria that we built into our Meditech system, and it's also our policy that we have in place. It talks about why the patient has [inaudible 00:14:05] catheter in place, yes or no. Then it

gives you all the symptoms, it talks about the criteria to continue the catheter. If the criteria is not met, you discontinue. If it is met, you have to get that physician order and also have to have the reason why you're continuing the Foley catheter. Next. Success and words of wisdom as far as what we did with this project. We have ED staff which will engage in the process since they were a part of developing the criteria. They were the first unit we rolled it out to. They began to look at removing catheters before the patient actually left the E room to get transferred to a nursing unit.

Criteria and protocol was spread unit by unit. We started with the ED, then we went to the fourth floor, because that's where most of our surgical patients went [inaudible 00:14:54] had Foley catheters inserted pre-op, and went to the seventh floor, which is another [inaudible 00:14:59] unit, and now it's hospital wide. We did use quality insights [inaudible 00:15:05] on their teams [inaudible 00:15:07] networking. They were extremely helpful to us [inaudible 00:15:11] help run reports for us, charts to us that show the success we have, which we had posted on the units. I heard one of the [inaudible 00:15:20] say, Jane, I believe, said remember when you do have a successful project to reward your staff. We always [inaudible 00:15:27] explicitly [inaudible 00:15:31] the staff [inaudible 00:15:31] a part of the process and [inaudible 00:15:37]. Like a little card you send around saying thank you for your help, or if you give them a tray of donuts. Something to show them how pleased you were that they were involved and helped make this project work.

We had our goals and expectations met because we did have a decrease in CAUTI. We had cycle interventions, which was really important because instead of months and months and months to fix a project, we got the cycle interventions in place with our ABC process. One of them was a criteria for maintaining catheters based on the protocol we had in place. [inaudible 00:16:07] our threshold. To show that, we had from 2011 and 2012, 2 years, we had zero CAUTIs in our facility, and we were really, really pleased with that. We have that posted all through the hospital. We have star pictures around for the staff on the floor so that they could see the success. We posted the results on the unit. We posted them for the medical staff. We also share them at our board level meetings. Urinary catheter utilization rate in our facility when we started the Quality Insights project was 19.6%, and by February of 2014, we went through the project, we were down to 15.7%.

We really, really did see success with decreasing CAUTIs in our organization. These are the charts that we share with staff. You can see when we started, we were pretty high, back in 2008. We ended it in 2013, and we'll show you the following year, but [inaudible 00:17:07] below our benchmark. You can see where we are currently, a little bit up in the fourth quarter, but we're still below the benchmark. One thing I could say that's really important, remember to

maintain and sustain, because once you stop looking at something, you have a tendency to fall back, and you don't want to let that happen. We were pleased with the results we had. We were pleased that we could be part of the collaborative Quality Insights, and we're going to continue to join these projects this year. Thank you.

Eve: Great presentation. Thank you so much for sharing your strategies and your success with us. We are pleased to introduce Maureen Speckle. Maureen is an advanced practice nurse and clinical nurse specialist for medical pulmonary critical care at Christiana Care Heath Services in Newark, Delaware. She works on system wide, evidence based projects with a focus on critical care, and is also the sepsis coordinator. She is currently the co-lead for the 2014-2015 [inaudible 00:18:15] CAUTI collaboratives, and a member of the CAUTI reduction [inaudible 00:18:20] committee. Maureen?

Maureen: Thank you. It's a pleasure to be here. Thank you so much for the opportunity to share, but also to learn from others today. Christiana is a big hospital. We're about 1,100 beds, and it's a 2 hospital health care system. Next slide, please. Some of the underlying things that are so significant, and I won't go over every detail, but 2010 was a big year for us, and really impacted us in a big way, which we're still seeing the effects today, which is a good thing. In 2010, the ICUs at Christiana, Wilmington Hospital all joined as a CUSP initiative to stop BSI, bloodstream infection. CUSP is the Comprehensive Unit-based Safety Program, but it's had a ripple effect in the way that we practice and our philosophy.

It brought a team approach to debriefing all health care acquired infections or any acquired issue, and it brought front line team members to the projects. Also, we developed a really close working relationship with our infection prevention nurses at the time. They were part of our team, but they were really embedded in the team. As we morphed from bloodstream infection, we included all of our other pieces into projects and teams. [All 00:19:38] the ICUs moved into what we called Value Improvement Teams in 2012. A lot of projects were now co-collaborative between the ICUs to work on CAUTI, to work on CLABSI, to work on skin, to work on many projects together. We formed a daily goals checklist at the time, and I will show you some pictures of that. Also, the system had task force for UTI reduction. With the ICU, it was a big part of being some of the major focuses of infection.

2004 we had a [re-surge 00:20:06] in the CAUTI collaborative, and we did some practice surveys, which we'll also share with you too, and a lot of EMR enhancements, which I have a lot of pictures of for you. 2005 was also a very big year for us, and we went live recently with new products. We now have CAUTI prevention specialists and training and checklists. Also, [inaudible 00:20:30] go about with a new skin product trial also. This id an evolving course of events.

Next slide. This copy of the daily goals checklist, and if you advance it one more time, there's an animation in there. On the checklist, which we started and piloted in 2011-2012 in 2 ICUs and in 13 adopted into all, among other things, the Foley date inserted and removed is at the top of the form as a reminder. Advance one more time.

Then, can this Foley be discontinued is part of the daily dialogue in every ICU on grounds every single day. Next slide, please. The catheter report, and that was e-mailed to nurse managers and some select people over the years. In 2014, we morphed it to a form that is printed on the unit. That unit's number of Foleys, and it goes 6:30 and 6:30pm. It's [inaudible 00:21:29] nurses and to validate what Foleys are actually in patients. That's actually been a huge resource for people to understand what's going on. The reason, who has the Foley, and that's all very much documented. People can use that for their unit guide. Next, please. In 2015, we implemented an electronic checklist, borrowing things off of CLABSI, which we've had an electronic checklist for a long time. It's able to do one-stop shopping for everything. It's documenting that you use the proper technique, but it's also cemented documentation across the board so all units are documenting in the same way on this electronic medical record form. Next slide, please.

[inaudible 00:22:17] our Foley orders, which is also electronic in our health care system. Can you advance it one more time please? Foley catheter palliative, not managed by other means as one of our orders. Actually, that was a request from our emergency department who was seeing a lot of patients come in with palliative care needs for Foleys. That's the newest order to our revision. We've had an electronic order set for a number of years. Next slide, please. To our Foley indication assessment. Not only are we documenting a checklist when we put in, but every 8 hours, we document the continued need for a Foley [inaudible 00:23:00]. All the documentation from the insertion checklist then moves over to the Foley indication. Next slide, please.

Very briefly, this is a short talk about the survey we did in our collaborative in 2014. The results were different, and not probably what we anticipated, but it's given us food for thought and action to move forward for, particularly in our ICUs. Can you advance one? [inaudible 00:23:30] insertion was only done 81.47% of the time, which was a lot lower than we were anticipating. I'd like to see 100. Next advance, please. 94, certainly would have liked to see 100. Advance, please. Catheters, even though we had a policy stating 100%, were only being used 68%. Next advance, please. Closed 81% of the time. Bladder, thinking that was fairly no-brainer, was 65.9% of the time. Next slide, please. Routine perineal care post-insertion. This is [inaudible 00:24:09] perineal care of any patient with a Foley was really only reported by nurses being done 36% of the time.

This was disappointing, but gave us a path forward. Next slide, please. In '15, we had a WebEd mandatory for all RNs and PCTs both on insertion and certainly maintenance for the PCT. We updated our procedures and guidelines, had new definitions for urinary retention that were clearer, and clearer guidelines on procedures, including a straight catheterization algorithm. We also got new products in that was a little bit more inclusive, and had Peri-Care brought right into it, closed systems, and a lot easier to use for our people. Next slide, please. We had this new technology now, we call these CAUTI prevention specialists, and they're actually, we have buttons, orange, for yellow, for urine. Multiple trained CPSs or RNs and PCTs on each unit from their own value improvement teams. CPSs are a great resource for that. [inaudible 00:25:11] training for new products and new things, but also helpful in the performance improvement and looking at Foleys on a daily basis. They're a great resource on the unit.

We plan to have biannual meetings with our CPSs. This is a new designation, just of January of this year. Next slide, please. The successes in individual ICUs, our surgical critical care complex has 22 beds, but they [inaudible 00:25:37] studies and have presented at national conferences looking at Castile soap as maintenance, Peri-Care [inaudible 00:25:45] and have had good success with their product. Slide, please. [inaudible 00:25:52] has been outstanding. They're a small ICU, although they might be [inaudible 00:25:56] ICU. They've won several awards for their individual unit success, and they have not had CAUTI infection in their ICU since quarter 2 of 2013, which is outstanding. Next slide, please. [inaudible 00:26:10] care complex. They won a nursing excellence award at the Christiana Care Health System. They're working diligently to bring down their device utilization. Next.

Unit success. The medical intensive care is the 24 bed unit, and we've been well below the [inaudible 00:26:27] for utilization since quarter 2, 2012, and had a [inaudible 00:26:32] focus on excellence for our decreased utilization for Foleys. The Neuro ICU is a brand new ICU that opened up in 2013, and I think the graphs are very small for you, but the red dotted lines are what the NHSN rate is, and the blue line is what Christiana Care is doing for their utilization in those ICUs. Both these units are way below. Next slide, please.

[Combined 00:26:57] slide. I know that the NHSN mean isn't the same for all ICUs, but it's averaged here, just for the depiction. The [blue line 00:27:05] is really where our device utilization has been decreasing in all ICUs over several years. If you look at 2011, which was really a pivotal year for us, because it was basically the year after the CUSP team [inaudible 00:27:18] got going. It really translated very well over to CAUTI and all of the ICUs, and the teamwork that was going on. Our infection rate is steadily decreasing. Can you advance just one more? I'd love it to be zero, but for the first quarter of 2015, in our ICUs, we've had 5 infections, and that translates to roughly about 2,100 device [inaudible

00:27:42] a quarter. It's really phenomenal. That's much more progress than last year. We continue to make progress with our infection rate in our ICUs. The next slide.

The take-home message for us at Christiana in our ICUs particularly is that we have embraced this collaborative philosophy, this teamwork, that everybody makes a difference. In most of the ICUs, every single nurse and tech and PA and whatever staff you have is a member of some part of the value improvement team in the ICUs, where that had not really existed before 2010 and the CUSP philosophy. Everybody can make a difference, and everybody really does make a difference. Thank you.

Eve: Wonderful presentation, Maureen. It was great information, and great success. Thank you so much for sharing with us. At this time, I'm going to see if we do have any questions, and I think we had a couple here besides the fact that the slides weren't advancing, and we do apologize for that. Here is one question, Maureen. Strict INO in the ICU is our most frequent indication. Do you use a strict INO protocol for the ICU?

Maureen: We don't, actually, and that's been the hardest part, to get the physicians and the physicians' assistance and [inaudible 00:29:12] used to that. We do have weight, and we do a better job at weighing patients, but strict INO, sometimes we'll give them a 24 hour period, but frankly, unless they're actively resuscitating them, it's an active discussion, but strict INO does not get you a Foley.

Eve: Very good, all right. A comment I want to mention to everyone asking about the slides, the slides are posted on our website, and I will make sure that link is posted again if it's a Q&A, but they're easily found under events. There is a question, I think this is for Maureen, can the Foley insertion checklist be shared?

Maureen: Well, it's shared on the slide. Do you mean shared by e-mail or shared ...

Eve: I think that's what she means. Maybe she could just e-mail me directly and I could pass her e-mail to you?

Maureen: Not a problem. We do use [Serner 00:30:10], we're a Serner System.

Eve: Thank you. We have almost 100 people on the line, so that's a great participation. Please feel free to type in some Q&As. We have a couple minutes here. I did have a couple questions. One for you, Maureen, as far as how did you identify your CPSs?

Maureen: I let them self-select in their own units, and most of them came from their own value improvement teams. Several members say I'm coordinator of the medical

ICU, several members of our own cavity and skin value improvement team became CPSs on the unit. I think every unit did it a little bit differently, but they did send people that were already involved in CAUTI or maybe from their education counsels also, but part of their value improvement team.

Eve: Sounds great. I wondered about that. This really is a question to both of you, to Andrea and Maureen. Progress with our project. I'll just clarify. When we look at CDI, we go by [lab ID 00:31:16] event, so we [inaudible 00:31:20]. When we look at CLABSI and CAUTI, we do select units to [inaudible 00:31:26] in our project. We meet with [inaudible 00:31:33] question like what units do we select. Obviously, it's units that you may have issues, and obviously, Andrea, you guys kind of thought out of the box when you went to work on the ED and see how that impacted other units. Sometimes it's other things, and maybe not as tangible when you're looking at units to really focus on for improvement. Maybe it's culture of the unit. I just wondered if both of you could comment on like what you're selecting a unit for improvement, what sticks out to you as a unit that would really make progress and reducing HAIs?

Andrea: [inaudible 00:32:16] we realized that was an area where we saw really high utilization rates of Foley catheter use. [inaudible 00:32:23] the hospital, the unit we identified, and how we did it was we ran reports and we looked at utilization, [inaudible 00:32:30] and catheter use, we found that the fourth floor, because it was our highly surgical floor, then the other unit in the hospital, the fifth floor is our [inaudible 00:32:40]. We found out through the surgical unit that many of the Foley [inaudible 00:32:46] that were being [inaudible 00:32:46] were being kept in [inaudible 00:32:50] and everything else going on. You're looking at the [inaudible 00:32:54] a catheter within a 24, 40 hours, unless there is a really good reason why that Foley should not be removed. We decided to look at the surgical unit because in our ABC process, it taught us to look at the area where you have the most potential for improvement. That was the fourth floor and the seventh floor.

[inaudible 00:33:14] look at the [inaudible 00:33:18] unit because that's where your congestive heart failure patients, the majority of ours were admitted to. It's just looking at the actual reports of those units and seeing where the catheter use is highest and why before you can maybe have an impact on improving the way you use the Foley catheter. I think sometimes it becomes a convenience. It's easy to put a Foley catheter in someone. You don't have to worry about taking them out to the bathroom or whatever. That's not the reason to insert a Foley catheter. So that's how we did it.

Eve: Okay, good. Maureen, could you comment, please?

Maureen: I think the cultural changes are probably the most important. I truly think that we learned that from CUSP, but it could have been from other collaboratives. Neuro ICU was new, and was not part of the original CUSP initiative. They're actually undergoing CUSP now to look at ventilator associated pneumonia, and essentially, to drink the Kool Aid, to drink the water of the collaborative ways of learning and the teamwork and the integration of the entire team into that. One of our endeavors, one of our high units in the hospital was this medical pulmonary step down. We sort of migrated the ICU that was attached to that unit for a number of years, and so was the infection prevention [inaudible 00:34:30]. The cultural changes of CUSP that you can make a difference and you keep at it, and we've had some wonderful success. They're actually presenting at national conferences this year for both their decreased CAUTI rate, they haven't had any in several months since last year, and also, their decreased utilization. This is long-term, complex pulmonary medical patients. It's really a lot of the cultural stuff.

Eve: It is. Yeah, those neuro rates, that's impressive. I have another question, kind of a comment. I'll tell you, where we're at with time of the webinar, the way I'm going to handle this, is [someone ask 00:35:10] and I'm going to put this in chat and see if we can get some comments from the other hospitals on the line. She said I had a physician that once [inaudible 00:35:21] all patients that are sedated [inaudible 00:35:23], does anyone else have this problem?

Andrea: That's unfortunate.

Maureen: I can't help you with a particular physician, but we have patients on paralytics that were still straight [cathing 00:35:35] in an ICU on [pressers 00:35:38] and everything, straight cathing every 2, 6, to 8 hours. It is possible.

Andrea: That is [our 00:35:46] infection, [you own 00:35:48] the infection, so the [inaudible 00:35:49] part of the unit, and the nurses own it, and the medical director owns it or the surgical director. It's really not fair and not very teamwork for one person to dictate and not do the best practices.

Eve: Very good comment. Okay, I'll post that particular comment in chat for everyone to respond to. Please, we don't mind a robust chat going on while we're presenting, that's perfectly fine. I really appreciate what Andrea and Maureen have shared with us. Thank you guys so much. Before we started, we were talking about the meaning of a collaborative, and this is it, and it's because people like Maureen and Andrea are willing to share and spend time reaching out to everyone else. Thank you again.

Andrea: You're welcome.

Eve: At this time, I'm going to turn the presentation over to kind of the more technical piece. We're going to start talking about reports, and I'm going to turn it over to Ronnie Summers is the data analyst for the reducing [inaudible 00:36:55] in hospitals project. Ronnie, and then I'm going to try my best to get your slides up here without any more glitches.

Ronnie: I'll talk a little bit about a strategy that was developed by the CDC called TAP, or Targeted Assessment for Position. This is an [inaudible 00:37:23] that measures data for action to [inaudible 00:37:26] health care assisted infection. [inaudible 00:37:30] used it to identify excess infections in specific units within a facility so that an infection prevention can be addressed in the targeted location [inaudible 00:37:44] metric called the Cumulative Attributable Difference, CAD. The C is the number of excess infections within the unit or [inaudible 00:37:59] for an overall facility. The report ranks units by the CAD to help power task prevention efforts where they will have the most impact. It represents the number of [inaudible 00:38:12] that must be prevented to reach an HAI [inaudible 00:38:16] goal. A little later, we will talk about how to calculate a CAD and how to use it to set goals. Next slide.

                    There are reports available in the NHSN in the analysis section. There are [inaudible 00:38:34] reports available for CAUTI, [inaudible 00:38:36] and CEI lead by the [event 00:38:37]. Next slide. TAP reports. [inaudible 00:38:45] the NHSN under the [inaudible 00:38:47] you click on the analysis section and basically follow these steps. Next. Here it shows you what it looks like when you go on the NHSN to run a report. Probably familiar with the blue navigation bar on the left side of the screen. Here, click on analysis, and bring up the option to generate data sets and output option. For up to date reports, you always want to click to generate the data sets before running any reports. To run a report, you have to click [that 00:39:27] first before you can run your first report. Click to generate, a progress bar displays on the screen showing progress towards completion. It only takes a few minutes, you do not have to sit there and wait for it.

                    You can go to other parts of the NHSN and work and come back, or you can even log off and come back to it later. Finished, you will know it's done because if you click on generate [inaudible 00:39:56], the last date generated is what will display instead of the progress bar. [inaudible 00:40:03] and you run a report, your data will only be as fresh as whenever was the last time you generated data. [inaudible 00:40:10] is complete, then you can click on the output options to display a list of the available report modules. Next slide. Once you've gone to the output option, then click on TAP reports. On my screenshot shows acute care hospitals, but it lists several different health care [inaudible 00:40:33]. Click on the acute care hospitals, under that, you click on CDC defined output, and you see the list of the available TAP reports.

These are 2 options for running reports. You can click [inaudible 00:40:49] button, and that will display a report on your computer screen. It will run a report on everything you've ever entered into NHSN up until where you last generated the data. [inaudible 00:41:05] everything, then you can click the [inaudible 00:41:07] button. We don't have time today to go into great detail on this, but on this other screen, there's the option to pick a specific time frame, rather than doing everything. There's also an option to send a report as a PDF file or a Word document. There's also an option to forward it to Excel if you wanted to do that. Off the screen, there's a box you can check that will, when your report runs, it will give you more [discreet 00:41:38] column headings. If you don't check that box, the real names are used on the report, and sometimes they can be a little difficult to interpret. Next slide.

Here's [inaudible 00:41:53] level TAP report looks like. Next slide, please. Into 2 sections, you see the first 2 columns are just the facility [inaudible 00:42:05]. This report is a report for more than one facility, so on those first 2 columns, you see the NHSN org ID and then the rank of the facility. You probably have more interest in the rest of the columns, which display the stats at the unit level. In these columns, it shows the location rank, which means the unit within each facility that has the highest CAD, or the highest number of excess infections is ranked number one. The highest [inaudible 00:42:39] CAD is number 2 and so forth. [inaudible 00:42:43] contains the unit location name, CDC location type, which is the number of observed infections, the [inaudible 00:42:53], [V2 00:42:54], which is the device utilization ratio, the CAD [inaudible 00:42:59], and finally, there is a count of some specific pathogens. Next slide.

Here is if you need to run a report for more than one facility. This is the facility level report, which has [inaudible 00:43:17] information except of course it doesn't have location name. Instead, it gives you a count of the locations overall, and how many are [inaudible 00:43:26] you, and how may are not [inaudible 00:43:28]. Next slide. How is the CAD calculated? It's an equation of the observed infections minus the expected infections. The equation, if you do get a positive CAD, that indicates that you had more HAIs than expected. These are excess infections. A negative CAD would indicate that there were fewer HAIs than expected. As you see in the graphic there, [inaudible 00:44:03] with the expected is 3.7, and the observed is 7. The calculation is 7 minus 3.3, which equals ... Which is the cumulative attributable difference.

Before we move on to the next slide, I want to talk for just a minute about the [inaudible 00:44:37] for anybody that maybe is not real familiar with it. SIR, or the standardized infection ratio, is another calculation that uses the observed and expected number of infections. SIR is the number observed divided by the number expected. [inaudible 00:44:55] and the expected ones are the same, which is equal to one. Less than one would indicate that the number of observed

HAIs are less than expected, or better than expected. One, or even better than that, a SIR less than one should be the goal. Next slide.

The CAD is in conjunction with the SIR to set an HAI reduction goal. The [inaudible 00:45:26] by setting a target SIR. Target SIR is a goal you set for yourself as part of your HAI reduction efforts. This SIR is then multiplied by the number of expected HAIs to determine what the expected number is for that SIR. This is then used in the CAD calculation. The CAD is the observed minus the expected, so [inaudible 00:45:55] calculation works for when SIR is unable to run. [inaudible 00:46:00] set a target SIR to be better than expected, say, for example, 0.75. [inaudible 00:46:06] becomes the observed minus the expected times 0.75. Next slide. [inaudible 00:46:15] when you try to set an HAI reduction goal [inaudible 00:46:20] the CAD.

Here are a couple of examples that demonstrate how using the SIR to set a goal affects the CAD, which is the number of HAIs that need to be prevented to reestablish the goal. For example, the target SIR goal is set to one, the number of HAIs is 4, and the observed number is 9. Since the charts are [in line 00:46:50], and you're playing [by the line 00:46:51], the equation is reduced to simply the observed minus the expected. In the first example, the CAD is 9 minus 4, which equals 5 excess infections. As an example, the target SIR has been set to 0.75, which the expected observed number stayed the same at 4 and 9, respectively. The equation becomes 9 minus 4 times 0.75, which is 6 excess infections. [inaudible 00:47:22] As you lower your target SIR, the number of infections that need to be prevented to reach that goal will increase [inaudible 00:47:31] know how many HAIs you reported, you may know where you want to set your target SIR.

We found the expected number of HAIs. Next. Then, in report, expected number of HAIs can be found in the SIR report, run it as very similar to running the TAP report. [inaudible 00:47:59]. This is very similar to running the TAP report. It's almost the same, except in part number [46 E 00:48:09], instead of running TAP reports, you run [CMS 00:48:12] reports. Next slide. Here's a screenshot that looks very similar to the TAP reports, but you'll notice that once you've clicked on the output options, there are all the modules there, instead of clicking on TAP reports, you click on CMS reports. That's basically the real difference, because through that, the choice of health care settings and [inaudible 00:48:40] shows the acute care, then you can [inaudible 00:48:44] defined output. Notice that there are more SIR reports than there are TAP reports, because the survey will [inaudible 00:48:51] other thing, but isolated the [inaudible 00:48:56] you're targeting, and the ones that get TAP report available. Slide.

This is an example of what a SIR report looks like. [inaudible 00:49:13] organization by location. If you have not checked the box that will give you more

descriptive headings, this is what you will see in the report [inaudible 00:49:23] for your CAD calculation, the number of observed and expected. [inaudible 00:49:30] infection count, do the number of observed HAIs and the num exp, number expected, as your number of expected HAIs. Next slide. The screen just shows a list of all the different aggregate reports that [inaudible 00:49:50]. When you run a report, it aggregates it various ways, by org ID, by the location type, location [inaudible 00:49:59], just different ways. CDI lab ID report is the same except there are no [inaudible 00:50:06] of location types [inaudible 00:50:09]. Next.

The simple way to determine your CAD, you can use the CAD calculator. That is the CAD calculator. The calculator will find the number of excess infections that need to be presented to the target SIR that you set. The information that you [inaudible 00:50:35] from the NHSN, [inaudible 00:50:37] will determine the CAD based on your target. This is a tool that will soon be available to hospitals that are participating in our reducing HAIs hospital project. Next slide. Calculator work. The yellow highlighted areas in the graphic, there, those are the areas where you can enter information. You can enter your number of reported infections, which is the number of observed infections, you enter whatever you want your target SIR to be, then you can enter the number of expected infections, or if you [inaudible 00:51:15] you can enter your current SIR. Any of those will work. Then the calculator will calculate the CAD, the number of excess infections.

An example where we have 2 infections, a SIR of 1.2, and a target SIR of 0.5. The excess infections is 1.75. The calculator tells you that you need to prevent 2 infections to reach the target SIR of 0.5, because of course you cannot prevent a fraction of an infection. Next slide. Another part of the TAP strategy is the CAUTI Initial Facility Assessment Tool. This is way to choose in conjunction with the TAP report to help [inaudible 00:52:06] problem areas. While this report helps to identify where to focus your efforts, it doesn't help determine what problems exist. As you get into [inaudible 00:52:17] based on units identified [inaudible 00:52:21] reports. [inaudible 00:52:23] is currently only available for [inaudible 00:52:25]. [inaudible 00:52:27] will tally the results for you once all the surveys are complete. There's another tool that will send you the available [inaudible 00:52:34] project participants. [inaudible 00:52:41] shows the major domains in the survey that include the general infrastructure, capacity, and process [inaudible 00:52:49] leadership, training, competency assessments, audits and feedback, appropriate indications for urinary catheter insertion, removal of urinary catheters, aseptic urinary catheter insertion, proper catheter maintenance, preventing candiduria and detection of asymptomatic bacteria.

This concludes my part of the presentation. I've left you at least somewhere between falling asleep and total confusion. With that, I invite anyone that wants

to contact me if they have any questions, if they need help setting an HAI reduction goal, or if they just feel like they need some clarification. I'll hand it over to Heather Banker from Louisiana.

Heather: I am going to take just a moment to go over resources and upcoming events. SIR and CAD tip sheet has been developed by Quality Insights, and will be available on our website. The tip sheet will explain more about [inaudible 00:53:57] SIR and CAD. Also, Ronnie has shared information on the TAP resources, including the CAUTI initial facility assessment tool and the CAD calculator, which will be available in the near future. [inaudible 00:54:13] is cosponsoring a webinar on May 20th with Philadelphia Department of Health entitled [inaudible 00:54:20] focusing on what works and what you have resources for with speaker Dr. David Schwartz. We will open registration for this webinar soon. [inaudible 00:54:33] have e-learning activities which will be available to participating hospitals 24/7. [SAUEs 00:54:41] will be offered for RNs. Stay tuned for more information to come. Contact information for each state as well as Ronnie's contact information. Please call us if you have any questions. [inaudible 00:55:00] back to Eve.

Eve: Thank you Heather [inaudible 00:55:08] being with us today. I don't see any additional questions in the chat or in Q&As. As I'm talking, feel free to type in [inaudible 00:55:23] that you would have in and I'll certainly look there before we close. I want to thank Maureen and Andrea again. I think Ronnie did her slides, so they're kind of like a handout for you when you're running the TAP reports. We've had a lot of questions about the TAP reports and it's all kind of unfolding as we go forward. Ronnie mentioned that the CAD calculator as well as that survey, those are options for you to use if you want to as you participate with us. We will have those available. We will definitely give you more information about that if you're interested. They're useful tools we hope you are able to take advantage of them. As you close the webinar, you're going to get a pop up with a very brief evaluation. Please take a moment and do provide feedback to us. We value that. We pay attention to it and certainly [inaudible 00:56:20] your comments going forward.

I don't see any additional comments. If you do, please feel free to contact me. The handouts are available. We've posted that site several times. If not, please get in contact with one of us on the contact screen. My contact is there, and we'll [inaudible 00:56:40] the link. Any other questions that you would have, maybe for Maureen or Andrea or Ronnie, send them our way. We'll make sure they get where they should be. At this time, we will be closing the webinar. Thanks so much for being with us today. Afternoon.

How did Ashley do?

☆☆☆☆☆

If you rate this transcript 3 or below, Ashley S will not work on your future orders