



# CMS 2012 Tri-Regional PACE CONFERENCE

Programs of All-Inclusive Care for the Elderly

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## TRANSCRIPT

### Tracking and Trending Infections

*Meg M. Wilber, RN, BSN, Coordinator, Quality Assurance/Performance Improvement, Catholic Health – Living Independently for Elders (LIFE)*

Good morning everyone. Thank you. I'm from Buffalo, New York. I don't know if there's any other Buffalonians out there in the audience. Thank you. But I would like to dispel the rumor that we have horrible weather. We've had our very, very mild winter this year with very little snow. I didn't even have to worry about wearing boots on the plane yesterday, so that's great news for all of us, but we are looking forward to a little bit more sunshine.

I am from Catholic Health Life, which is in actually in Lackawanna, New York, which is right outside of Buffalo, the home of Father Baker for any of you that might be familiar with him. And we are part of the Catholic Health system, which is a large network of hospitals, nursing homes, home care, and other types of programs. Catholic Health Life is about two years old now, so we are a very small program, too. We have about just under a hundred participants. I believe we're at about 94 now. So we're just getting started with all of our initiatives and programs as well. When I first started, my executive director said to me, one of the first things I need you to do is write an infection control policy and procedure. I've been a quality assurance professional for most of my career, so I thought, well I've written lots of policies, I've written QA plans, this will be no big deal, I'll just whip it off, you know, on a weekend. Well, I was sadly mistaken. I submitted my first draft to my regional office manager, and she tore it to shreds and said start over. So I did that a few more times. Luckily being in the System, the Catholic Health System, I was able to draw on the experience of other infection control professionals who helped me put the policy and procedure together. So I was very happy, very proud that CMS finally accepted that prior to our technical advisory review. And that is included in the book for all of you. And interesting enough, one of my previous work experiences, we used to go into a lot of – it was in research and we did a lot of poster presentations, and I thought, oh this would make a great poster. So I was really happy when Edwina Pierce asked if I would be willing to come today and speak about this because this might be a very overwhelming task for those of you who might be new to a PACE organization to sit down and write this. And I know for myself, it's always easier to see what somebody else is doing and get ideas from that, and build it to your own specifications. So I've included a lot of materials in the book and handouts that you could use, or you can modify. I have electronic versions of everything, so I'd be happy to share those with any of you.

So just to get started, what I'm going to go over today, and I brought everything that I have in regards to infection control. Kathy first asked if I would just talk about my infection control logs, and as you heard Peggy speak, they don't prescribe any type of format for you to use for your logs. They just want to see

what your logs look like when they come out to do the survey. So Kathy Fordham has asked me a number of times to share my logs with other organizations. Again, I didn't think they were anything special, but they're in your notebook for your review. So I brought that with me, and we're going to talk about tracking and trending. We're going to go over hand hygiene tracking and trending. And then I also brought the tool I use for environment of care rounds. So those are all in your book for you to look at as we're going through the presentation this morning.

I would like to just mention that when our participants arrive at the day center, one of the things that we have them do is use hand sanitizer before they even go into the day center. And then again throughout the day when they're using the bathroom, they are washing their hands and using hand sanitizer before lunch. I usually carry a couple Purell in my purse and in my pockets. When I'm in church I'm like passing it out after the sign of peace so everybody can wash their hands before they take communion. And it's kind of the standing joke at work that I don't go anywhere without my Purell bottle, but I can assure you I did not cough and sneeze all over the handouts, so they're perfectly safe.

What you'll see listed in the policy and procedure is that the IDT is a resource for all of our infection control practices. And they coordinate the process of infection control activities through the resources of the Catholic Health System Infection Control Steering Committee, which I am a member, as well as myself. I'm responsible for the oversight and reporting of the infection control program to the Life Quality Committee as well as the Catholic Health System Steering Committee for Infection Control.

In terms of monitoring, infections may be identified by a direct report by the participant or the caregiver. Many times in the morning when we are in our IDT meeting, our nurses or the transportation coordinator will report that four people called in that day that they're not coming, and we find out the reasons why they cancelled, and if one of them is that they're not feeling well or they're sick, our nurse will call them back to determine what the source of their illness is or what exactly is wrong. And oftentimes we'll say, oh no, you definitely need to come in and be seen. So if they come in to be seen, they'll go over to the clinic and then assessment will be performed, and either through the review of systems or the physical examination we might also identify that they do, indeed, have an infection. Oftentimes, too, when the participant's in the day center, one of the aides will approach me or someone else and say, you know, Mrs. Smith is coughing quite a bit, or she seems to be sneezing, or Mr. Jones, you know, came back today and he has a rash, or Mrs. Jones has been in the bathroom a number of times and that's unlike her. So our day center staff is very astute in identifying these types of issues which may lead us to believe that they have an infection.

If it's determined, after they're seen by the nurse practitioner or the doctor, that they do have an infection, the nurse, either in the day center or in the clinic, will complete the infection report, and then that's forwarded to me for reporting and tracking purposes. And I'll go through that in just a moment.

We track all kinds of infections in the program, but the major classifications that I'm tracking include the respiratory tract, urinary tract, GI, the skin, eye, ear and mouth, systemic infections, and the MDROs, which we all dread.

This is an example of a participant infection report, and this is in your notebook for your review as well. When it's been determined that a participant does have an infection, one of the nurses will complete the infection report, and it includes the participant's name, their medical record number, the date of the infection, the date of the culture if a culture was drawn or taken, what the results of the culture are, the type of infection that the participant has, whether or not this is a healthcare-associated infection, any

presenting signs and symptoms, any lab work or radiology results, and then the treatment. Once the nurse has completed this report, she forwards it to me immediately, and I log it into my Excel spreadsheet right away. After I have done that, I will then put it in a tickler file for myself so if the antibiotic is prescribed for five days, I'll put it in my tickler for five days. And I'll bring that back to the IDT meeting on that morning, and I'll say, oh, Mrs. Jones's antibiotic is due to be completed today. And the team will say, oh, yes, we have her on the schedule to be seen in the clinic, we have her on the schedule for a repeat urine. I'll give the form back to the nurse who initially completed it, and then if the infection has been resolved, she'll put the date of the resolution on there and give it back to me, and then I'll go back in and put that in my log as well.

Because we are part of the Catholic Health System network, if our participants are hospitalized or they are in long-term care, we're also notified of these infections. Our nurses go into the hospitals and also into long-term care on a regular basis to see our participants, so there's a lot of good communication going back and forth between these organizations and yourself so we're very aware of infections that are occurring with our participants. If our participants are in rehab or they've been in the hospital for surgery and they come back to us, and they develop C def or a surgical site infection, I then notify that hospital or rehab facility's infection control coordinator and make them aware of these infections as well so that we have good communication back and forth for their reporting requirements as well.

We also do repeat urine cultures on all of our participants with urinary tract infections to make sure that the infection has cleared up, and we are also looking for patterns and trends amongst the participants and within individual participants if they have recurrent infections.

This is an example of the log that's in your book. It is an Excel spreadsheet, and at the bottom, if you had the spreadsheet open, you'd see at the bottom the tabs along the bottom of the sheet for the various classifications that I'm tracking, and I'll walk you through these a little bit. I hope you can read them in the back of the room, the print is a little bit small. But basically what I put on the log is pretty much what is on the infection report that the nurse completes. The name, the medical record number, the type of infection, the date, the date of the culture and the culture results. And whether or not it's a healthcare-association, what their presenting signs and symptoms were, if there's any lab work or radiology results, the treatment, and the date of the resolution. So, for instance, this is a – the first slide here – is a respiratory tract log. So you'll see that some participants had a URI, or pneumonia, so there was a positive CT of the chest, which was indicative of the pneumonia. What the treatment was, and then the resolution of that. We had a participant who tested positive for the flu and also had pneumonia, and what their signs and symptoms were. And this particular participant could, indeed, have a hospitalization for that, so that would be important to communicate as well.

The next part of the log is the urinary tract. And you can see that we always include the culture results for each participant and what the treatment is. The treatment may change as well based on the culture results. Oftentimes if the patient's extremely symptomatic, they'll get started on one antibiotic and switch to another antibiotic once the culture is back.

This is for GI tract. Participants with diverticulitis. The skin – oftentimes there might be a culture of the skin to determine what is going on with the participant and the best course of treatment.

I believe in the book there's only one page of the log, but for the classifications I have a tab for each one of those.

The eye, ear and mouth, conjunctivitis. Whenever we have a participant that's identified with conjunctivitis they stay at home, at least for the first 24 hours or until their drainage has stopped and they are not allowed back in the day center until they've been cleared, so when they arrive they go right over to the clinic before they're allowed back into the day center so they can be cleared, because the last thing we want is to have a – a run of conjunctivitis.

A log for systemic. And then the MDROs. And then I also have a log for other, for things such as post-op wound infections or other types of infections that might not be captured on the other logs. At the end of every month, I then transfer all that information onto a tracking sheet, and that is also in your notebook. The denominator for any given month is the number of participants that are in the program for that month, and the numerator is the number of infections. And I have broken the tracking sheet up into the major classifications, again, UTI, URI, GI, and so forth. And then I will have a given month's statistics as well as a year-to-date statistic for the infections.

I also look back at the previous month and the previous year when I'm tracking these infections to see if there are any patterns or trends. And also when I'm tallying this up for the month, too, you can see if a participant has had an infection in more than one category, which is useful information, too. This is all shared with the medical director, and we review this each and every month to look for patterns and trends. This is also shared on a monthly basis with our quality committee, and we go over this very closely on a month-to-month basis. We don't wait until the end of the month. If we notice that we're having a pattern or a trend, at our IDT meetings we look into this and – and try and identify what is going on so that we can address it as quickly as possible.

The next thing that I wanted to talk about this morning is hand hygiene. And I put the hand hygiene policy and procedure in the book. This particular worksheet, the hand hygiene observation tool, got mixed in with the policy and procedure, but it is all in there in the book. And you'll see that I've included the policy and procedure for re – for your review. And then this hand hygiene observation tool is something that's used by the day center nurse, the clinic nurse. We also have the day center manager doing hand hygiene observations as well as our recreation therapist, who's in the day center. And they will collect information on observations day to day throughout the month. And again, I coded them into physician, the nursing and aide staff, dietary, the environmental staff, rehab therapy, social work volunteers, and then what are the opportunities that were observed, you know, before, during and after patient care, before meals, things such as that. And the opportunities are either for hand washing, hand sanitizing, or they observed neither of those. And then those tools are turned in to me at the end of the month, and I put them on this tracking sheet again, which is very similar to the other tracking sheet, and I break that down into physician staff, nursing staff, environmental and rehab and so forth. And the denominator is the number of observations over the numerator, which is the number of times the hands were washed or they were sanitized. And then we have a percentage for each category, as well as for the month and then year-to-date totals.

And I have to say that this is actually our results for 2011, these are the actual results. And on any given month we're doing, you know, 25 or 30 observations. As we've grown we've just added additional nursing staff so we'll have even more observations on a monthly basis. But we do very well with our hand washing, and I think that really has helped to contribute to the number of infections that we have, and I'm kind of the hand washing Nazi at the center. I'm always watching people. In IDT meetings, if people are coughing and sneezing, I pass out the Purell. We're just really on top of this to keep our infections down.

The next thing that I included in the booklet is the tool that I use for environment of care rounds, and I apologize for the small font. It will most certainly challenge you visually. I do environment of care rounds every month, and I use this tool and I go through the clinic and the day center, the area where the participants arrive every morning. I'm looking up, down, sideways, all around. I'm looking for stained ceiling tiles. I'm looking for shipping boxes that are on the floor. I swear the red alert goes out when they see me walking around so that everybody can hurry up and clean up their areas, but we do have some clutter bugs that work for us, and it's important not to have all that clutter around and it can cause some real problems. So we – I look for things such as the practice issues, the supplies in storage, general environmental types of things. I make sure that privacy and confidentiality I maintained, and just general observations throughout the center. And then what I do is as I notice things that might be problematic, I collect all that information and I send this tool out to those individuals on a monthly basis whose areas are in need of correction and ask them to correct those areas and respond back to me when those areas have been corrected. And they're real good about cleaning up or doing whatever needs to be done. Our facility guys will come in and replace ceiling tiles as they need to and get rid of those wet marks on the ceiling, and those are all done very timely.

All of this information from the infection control, tracking and trending, to the hand hygiene, to the environmental rounds, is all shared on a monthly basis with the medical director ahead of the quality meeting and then again with the entire staff at our quality meeting, and this information goes up to the system steering committee, as well, for their information and also for any feedback that they might have. So it's interesting to be part of that steering committee because I can see what's being done in the acute care hospitals, I can see what's being done in long-term care, and I can bring that information back and share it and decide if we want to adopt any of those practices. I'm also kept in the loop when there might be influenza outbreaks and things like that, or I come back and say, oh, did you know that there's, you know, been some identified cases of Hepatitis B from glucometers, you know, how are we sanitizing our glucometers, look at our practices and things of that, and so it's very, very helpful to have that information and be part of that larger steering committee.

Are there any questions on any of the materials or any of the examples that I brought?

And that the best practice nationally with covert observation about 90%.

Yes.

So – so, how – how – what have you been doing that really worked with your team and the second part of that is, what have you been doing on the home care side because so much of what PACE does is actually in the home?

Yes. Yes. When the aides or the nurses are being observed for hand washing, there's not someone standing there with their clipboard watching them wash their hands and counting to 20. Our people are out in the day center – our staff is out in the day center all day long. And they are observing the aides wash their hands when they bring the noon meal, they're watching the dietary staff bring the noon meal in, and they'll just go back to their office or whatever and say, oh, yeah, here's my clipboard with my sheet, I saw three or four people wash their hands today, or, you know, if I'm just out, you know, getting my lunch out of the refrigerator and it's lunch time and I see all the aides washing their hands before lunch, if they're not doing it properly, I will go over and educate them and I will take credit for those observations as well. So, and I am, you know, I am out in the center a lot. So are the other nurses, as well as our day center manager, looking at other things, addressing other things, but all day long you're

there, you can see people washing their hands or not washing their hands. So, I'm sorry, what was the second part of your question?

\INAUDIBLE\.

Yes. Absolutely. And there's a lot of education that's provided in the home as well. Yes.

What's your relationship with your wound care team if you have one, and how do you rate your infection control efforts with them?

We do not have a wound care team at this time. We are working to get some of our nurses wound care certified. Actually this coming weekend there's a seminar that they'll be attending for that. We do have wound care specialists in the system, so when we need consultations with – with – for wound care, we also have a wound care division within Catholic Health that we send many of our participants out to see the wound care doctors. But we do not have a wound care team.

Hi.

Hello.

Just getting back to the environmental component of your – your role, as a former long-term care surveyor, I was part of a team that – that was contemplating calling immediate jeopardy on a long-term facility that – that had a cleaning protocol that seemed to be – fly in the face of good practice in terms of minimizing the spread of infection, which is to say they were like mopping from dirty to clean, and so it occurred to me in my new role as a PACE reviewer, account manager, that that's – that's probably an important component of an infection control program, which is to say to actually have documented in a policy and procedure a cleaning protocol for the – for the housekeeping staff. Do you have anything like that, and just to the group at large, is that something in your policy and procedure?

No, it is not something in my policy and procedure. We contract for our environmental services, and our environmental service team is also part of a facility-wide safety team that we have, so I sit on that team and I am exposed to their policies and procedures and their practices as well. But, no, it is not included in my specific policy and procedure.

Any other questions? Okay. Thank you very much everyone.