HEALTHCARE BUSINESS INSIGHTS

PATIENT CARE DELIVERY

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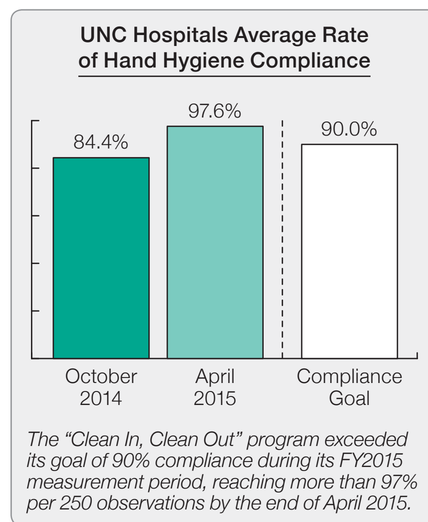
Promoting Patient Safety Through Hand Hygiene Surveillance and Peer Feedback

Infection poses a serious danger for all patients, with myriad sophisticated control and prevention efforts designed to minimize this risk. But, as clinical and non-clinical staff members are recruited to implement these various efforts, they may themselves serve as vectors of infection. While healthcare organizations may experiment with ultraviolet lighting and products with antimicrobial properties or develop extensive care bundles and stewardship programs to great effect, the simplest practices can often have immense significance in terms of patient safety.

Facing static compliance rates, UNC Hospitals of Chapel Hill, North Carolina sought to re-emphasize the simple, yet critically important, practice of hand hygiene. Through its "Clean In, Clean Out" program, UNC Hospitals has achieved steady compliance rates above its goal of 90% and fostered a broader conversation on the importance of infection prevention.

"We had a traditional program in place, but we found ourselves in a bit of a lull, as compliance improvements seemed to have stalled," says Dr. Emily Sickbert-Bennett, Associate Director of Infection Control and Epidemiology. "To bring greater staff attentiveness and interest to hand hygiene, we decided to make a robust shift in our efforts."



The "Clean In, Clean Out" program exceeded its goal of 90% compliance during its FY2015 measurement period, reaching more than 97% per 250 observations by the end of April 2015.

Opportunities for Staff Engagement

Prior to "Clean In, Clean Out", UNC Hospitals employed a more conventional hand hygiene compliance model, beginning with handwashing education as part of staff orientation, practice maintenance through updates from infection control staff, and "secret shopper" surveillance and data collection. Under this form of surveillance, a small number of observers would be assigned to specific units to anonymously survey staff compliance with hand hygiene

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Providing Hospital Services in a Critical Access Hospital via Hospitalists and Transport Systems

Decades ago, physicians in critical access hospitals worked in both the hospital and office medicine spheres. In the intervening years, this standard has shifted to physicians practicing in either one or the other, with many providers choosing office medicine. As a result, demand has grown considerably for hospitalists in smaller hospitals that lack staff capable of providing critical care to patients.

CARILION CLINIC

Carilion Giles Community Hospital (CGCH)—a 25-bed critical access facility located in Pearisburg, Virginia and an affiliate of Carilion Clinic—is one such organization that has instated a dedicated hospitalist program to serve the needs of its patients that require hospital services. In addition to staffing hospitalists that round twice a day, the organization also utilizes a transport system to assist critical care patients needing services from a larger facility.

"There are advantages to the hospital programs, but the advantage of my background is that I know both sides of the equation," explains Dr. Michael McMahon, physician and hospitalist. "I know what things are available on the outpatient side and how it works, as well as the hospital side. But if you only do the hospital side without ever working in the outpatient, you don't know how processes flow and that can cause problems."

Adopting Hospitalist Practices

Initially CGCH's physicians practiced both hospital and office medicine, but over time, many of the physicians switched to strictly office medicine and only took appointments in the office environment. To overcome this transition and help provide a wider range of services to its rural community, the organization hired one full-time hospitalist to provide that care. In 2010, Dr. McMahon joined this physician in adopting hospitalist responsibilities. Currently, the organization has one full-time and two part-time hospitalists in practice.

"It was probably five or six years ago when there was a lot of pressure to stop doing both," Dr. McMahon says. "Everybody at our office wanted to just do office medicine, and I wanted to continue with hospital medicine. That's how the hospitalist program sort of evolved at our organization."

These hospitalists at CGCH make rounds about twice a day within their 12-hour shifts, take care of about 95% of the patient

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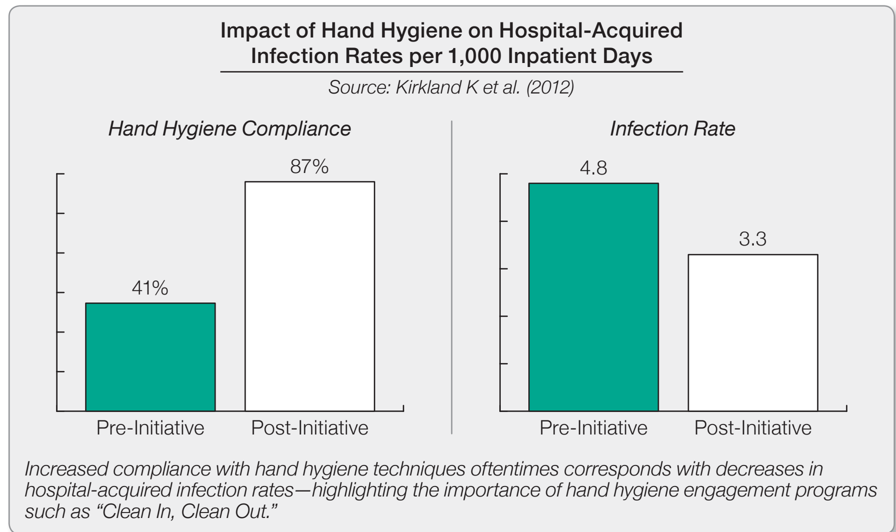
requirements. Data was limited in scope, little feedback prevented widespread cultural changes, and static compliance scores indicated lagging staff interest. Additionally, perceptions of the simplistic nature of hand hygiene often overshadowed its real impact as an effective safety initiative.

"I think a lot of hospitals struggle with getting healthcare professionals excited about handwashing, and we were certainly in the same boat," Dr. Sickbert-Bennett says. "Considering all the complexities they deal with on a daily basis, it almost seems too basic to have to remind them to do something so simple."

To drive a renewed effort toward greater hand hygiene compliance among staff, UNC Hospitals turned to an existing, successful model trialed in the pediatric intensive care unit. Based on the premise of observations conducted by peers rather than infection control professionals based outside of the unit, this program showed greater engagement among staff members toward improving their own compliance. Seizing on this opportunity for wider engagement and improved infection control practices, the team behind "Clean In, Clean Out" expanded the program throughout the hospital.

Impact on Staff and Care

When the program went hospital-wide three years ago, those promoting it aimed to keep simplicity in mind. Any time there is an interaction with the patient or their space, whether physical contact occurring in the regular course of care or entering the room to change out a trash bag or deliver a food tray, staff members are required to properly perform hand hygiene upon entry to the room and after exiting. Infection control staff set suggested observations at five per month, with observers utilizing paper tools to document relevant data that is compiled electronically into a usable form for analysis by infection control staff. Hospital administration further encouraged compliance by including hand hygiene in the organization's annual quality goals, formally tying the effort to broader patient safety and satisfaction aims.



Increased compliance with hand hygiene techniques oftentimes corresponds with decreases in hospital-acquired infection rates—highlighting the importance of hand hygiene engagement programs such as "Clean In, Clean Out."

Moving away from a reliance on paper observation tools, infection control staff transitioned the program's data collection to an electronic survey tool, made available on the hospital's primary intranet homepage, which is accessible from every computer. Using this data, infection control staff produced monthly reports detailing not only total observations, but the number of unique observers and those departments that were most engaged in the program. This information allowed infection control staff to focus their efforts on specific departments and units where participation and compliance did not meet expectations and resolve any concerns that may exist therein.

In the second year after the program's implementation, infection control staff began measuring observation feedback in addition to the standard data. This response-based observation structure, while recognizing adherence to hand hygiene standards and reminding staff members when compliance had lapsed, had a more wide-reaching effect of fostering a culture keenly aware of the importance of proper hand hygiene and the hospital's commitment to it.

"Before we started the current program, the way we measured hand hygiene compliance would be limited to single observers on a given unit," Dr. Sickbert-Bennett says. "With our current program, we can have 10,000 observations every month, and half of those will have feedback associated with them. So we have very high compliance rates, but more than that, we have 5,000 times every month that people are talking about hand hygiene, which is an awesome statistic to me."

The results of the intervention highlighted the impact this cultural change could have on infection control processes. During the FY2015 measurement period, average hand hygiene compliance rates rose from 84.4% per 250 observations in early October 2014 to a high of 97.6% at the end of April 2015. Average compliance rates were not kept to infection control leaders, however, as each unique department performing observations is asked to post their hand hygiene numbers for all staff to see, as well as in a monthly newsletter outlining the program's successes. The availability of these results allows for staff members to hold themselves to high standards by having hard data to illustrate their collective impact.

"Hand hygiene is one of the simplest things everyone can do in the hospital, and really all we're doing is helping each other to remember to keep good habits," Dr. Sickbert-Bennett says. "It's really just one little thing, rather than hiring new people to just focus on hand hygiene compliance, that has been able to allow infection control to let go and empower everyone to be a part of these activities."

Through its focus on improving hand hygiene compliance rates, UNC Hospitals has been able to encourage a broader infection control focus among all staff members. By relying on the data collection ability of its staff, starting a conversation on patient safety through peer feedback, and recognizing the impact of clinical and non-clinical staff practices, healthcare organizations can drive broad patient safety efforts with simple handwashing—reducing infection rates and improving the delivery of care to patients. ■

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Building a Collaborative, Measured Home Infusion Program

For some illnesses, the prescribed method of treatment requires a period of therapy that may be more appropriately addressed outside the hospital. In these instances, many organizations utilize home infusion services—whereby patients are able to receive antibiotic therapy or parenteral nutrition on a periodic outpatient basis or in the comfort of their homes.

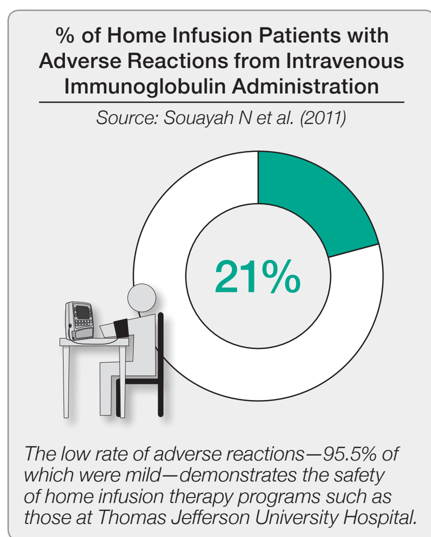
In order to learn more about the key staff members involved in home infusion care and methods by which quality can be monitored, The Academy spoke with Dr. Brian Swift, Vice President and Chief of Pharmacy at Thomas Jefferson University Hospital and Associate Dean of Professional Affairs at the Jefferson School of Pharmacy. Thomas Jefferson University Hospital is a 951-bed academic medical center located in Philadelphia, Pennsylvania.

Q: Who are some of the key staff members involved in home infusion?

Dr. Swift: The physician is the driving force in terms of prescribing the most appropriate treatment and deciding whether the patient is medically stable for home infusion, but it's really the nurses and pharmacists that form the care system for the majority of patients. They work collaboratively to meet the patient and assess their appropriateness for home therapy—considering psychosocial issues, cognitive abilities, and clinical abilities that influence their candidacy—educate the patients, and then provide ongoing updates regarding the patient and make care plan recommendations to the physicians based upon their collective findings.

% of Home Infusion Patients with Adverse Reactions from Intravenous Immunoglobulin Administration

Source: Souayah N et al. (2011)



The low rate of adverse reactions—95.5% of which were mild—demonstrates the safety of home infusion therapy programs such as those at Thomas Jefferson University Hospital.

Q: What would a typical patient enrollment look like?

Dr. Swift: For a typical patient, the pharmacist and the nurse meet with and assess the patient. We like to meet with the patient while they're an inpatient, but if we are unable then there's an introduction that takes place over the phone. Together, the nurse and the pharmacist look at all the related facts to see whether or not this is an appropriate candidate for home infusion, make sure the patient has insurance coverage for home infusion services, provide detailed education using the feedback methodology, and then put together the pieces of the puzzle that the patient needs to receive care at home.

Typically, a patient is seen at home within 24 hours of discharge by one of our nurses and then on a regular weekly or bi-weekly basis. The pharmacists look at the patient's current medication therapy and other medications that they may be prescribed to ensure there aren't any conflicting drug interactions. They also closely monitor patients for appropriate clinical response to treatment and potential adverse effects like renal toxicity. Really, it comes down to the multidisciplinary development of a precise plan to care for the patients.

Q: What other circumstances might prompt a patient to receive home infusion services?

Dr. Swift: There's also a population of patients that can't take oral nutrition, so they have to receive all their nutrition intravenously through total parenteral nutrition (TPN). In that instance, the dieticians and specialized nurses on the nutritional support team are key players in helping design the TPN formula. Then we monitor those patients in an extremely close way to see that they're responding to treatment in a favorable manner and to ensure that if there are any changes in their clinical status, we respond accordingly with timely acquisition of lab results and recommendations for modifications to the TPN formula.

Q: What quality metrics do you track to ensure that the program is maintaining that high degree of patient care?

Dr. Swift: We use a balanced scorecard based upon the different pillars that are consistent with our operation: quality and safety, patient satisfaction, focus on people, focus on growth, and focus on finance and operations. In the area of quality and safety, we look to make sure that we have better than benchmark figures for line infections. We look very closely at line infections because home infusion patients typically have a central line in place.

We also look to make sure that we don't have medication errors, that deliveries are done on time, that patients are satisfied with the services they're receiving, that they don't have pump malfunctions, that they're not on hold too long when they call for on-call supports, and for overall outcomes from therapy—all those kinds of quality metrics. To track patient satisfaction, we engage with the Press Ganey organization to monitor all of our home infusion patients in a similar manner to those that are in the hospital with a nationally benchmarked satisfaction tool with questions on it that pertain specifically to home infusion.

Q: What sort of advice would you give to an organization looking to develop its own home infusion program?

Dr. Swift: My strongest recommendation is to start with hiring the right people with the highest level of integrity and clinical skills. One of the approaches we took early in our home infusion program was hiring and maintaining our own staff of highly skilled home infusion nurses. These nurses are accountable to us and consistently care for patients that need these kinds of therapies. So I would say having specially trained nurses, pharmacists that are focused on clinical skills and clinical development, and a strong on-call support system are all important factors.

Also, it's important to understand the challenges that patients are faced with in the home care setting and build an infrastructure to support them safely. Home infusion is complicated and you're asking lay-people to do a lot. Having a structure in place that meets the needs of the patient and devoting appropriate manpower to building a strong clinical program is critical. It's not just a delivery service—by any means—and it's something that requires an appropriate level of clinical expertise to carefully and safely care for patients in the home care setting. ■

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population, and triage patients on arrival. To provide more comprehensive care, all staff, including nurses, occupational therapists, physical therapists, and case managers, meet three times a week to discuss the patient list and the discharge planning process for each case. This meeting allows staff members at CGCH to coordinate care with each other and facilitate a swifter discharge process.

"The system evolved so the hospitalist could see the patients at least twice a day, monitor things more carefully, pick up concerns earlier, take care of patients a bit better, and provide more information and satisfaction," Dr. McMahon notes. "Taken together, these things help contribute to quicker discharges."

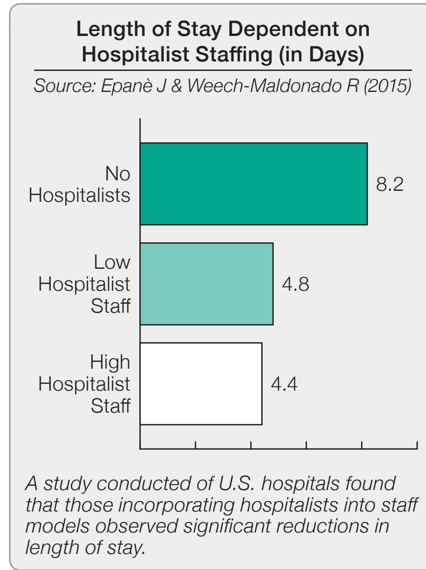
CGCH's patient population benefits from this critical access hospitalist model in a number of ways. Chief among these benefits, though, is that the local patient population is able to access an expanded array of services at CGCH—reducing the need to risk further health problems by travelling to the larger Carilion Clinic and encouraging patients to utilize health resources rather than skipping care due to inconvenience.

Transferring Patients

Due to its limited resources, CGCH has a specific admission process. Patients are always admitted through the emergency department if their acuity warrants either initial care or participation in a rehabilitation program after being discharged from another facility. CGCH employs both an orthopedic surgeon to treat patients with hip and knee problems and a general surgeon to assist with a wider range of procedures. If it is determined upon admission that these two surgeons and the hospitalist team cannot provide the appropriate care with CGCH's resources, the patient in question will be transferred to another facility. However, the organization strives to reduce this occurrence if possible by hosting a cardiologist once a week and access to an MRI machine twice a week.

Length of Stay Dependent on Hospitalist Staffing (in Days)

Source: Epanè J & Weech-Maldonado R (2015)



A study conducted of U.S. hospitals found that those incorporating hospitalists into staff models observed significant reductions in length of stay.

When a patient needs to be transferred, CGCH calls Carilion Clinic's Transfer and Communications Center. Designed in 2012 to help allocate bed placement within the region's healthcare facilities and with medical transfers, this center accepts phone calls from Carilion Clinic's associated sites and coordinates transportation between facilities. This service has helped CGCH with its triage and transfer process flows when its resources cannot meet the needs of severe cases.

As a result of these practices, CGCH has been recognized for its excellent quality of care through several awards. In 2013, CGCH's inpatient department won a 4-Star Award for Overall Quality of Care and four 5-Star Awards for excellence in communication about medications, communication with nurses, communication with doctors, and effective discharge information.

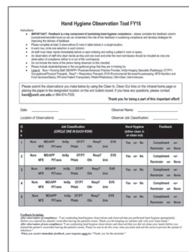
For critical access hospitals looking to provide more comprehensive services to patients, the hospitalist program at Carilion Giles Community Hospital can serve as a suitable example. By offering an expanded array of services and ensuring facility transfer and care coordination when appropriate, Carilion Giles Community Hospital is better able to meet the needs of its local patient population. ■

Now Available on The Academy Member Portal

Hand Hygiene Observation Tool

hbinsights.com/viewid/59452

This audit form outlines protocols for monitoring staff members' compliance with hand hygiene policies as they enter and exit patient rooms. It notes the importance of feedback in ensuring ongoing compliance and includes brief scripting samples for providing encouragement during instances of compliance and reminders during instances of non-compliance.



Suggested Keywords to Search: Hand Hygiene Monitoring, Infection Control Compliance, Hand Hygiene Feedback

Hand Hygiene Compliance Immediate Feedback Scripting

hbinsights.com/viewid/59453

This resource details sample phrases to assist staff members in providing immediate feedback when conducting hand hygiene audits. It provides suggestions regarding body language and tone, as well as recommendations for responses to common counterarguments—such as avoiding contact with the patient.

Suggested Keywords to Search: Hand Hygiene Compliance, Feedback Scripting, Infection Control Monitoring

Download these tools from our members-only website. As a reminder, your email is your user ID. To set up accounts for additional members of your team, contact The Academy's membership services at 888.700.5223. We would be happy to schedule an orientation for new members!

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