Healthcare Acquired Infections
February 23, 2007
9:30 – 11:30 AM
Minutes

Attendees: Wendy Furniss, Jill Kentfield, Jeanne Hamilton, Jean Rexford, Richard Garibaldi, Brian Cooper, Diane Dumigan, Jackie Blake, Harry Mazadoorian, Pat Monahan, Julie Petrellis, Louise Dembry, Joanne Chapin, Hari Chanda, Susan MacArthur, Brenda Grant, David Neville, Jennifer Barrows, Jennifer Martin

The meeting was called to order by Wendy Furniss at 9:40 am.

The minutes of February 16, 2007 were approved.

Julie Petrellis provided a status on the survey of hospitals. The final draft is being pulled together and will be available by the next meeting.

Jeanne Hamilton was introduced to the workgroup to speak about the experience she had with her 91 year old father. He fell while at a nursing home in Bloomfield and sustained a head wound. He was sent to the hospital to rule out the possibility of a stroke. He received stitches at the hospital and was kept for 4 days, then sent back to the nursing home. He was sent back to the hospital the next day, where it was confirmed that a staph infection had occurred in his wound, which was promptly cleaned and re-stitched. He was kept at the hospital but never recovered and the family made the decision to discontinue life support. The death certificate states cause of death was heart failure.

Education:
Other states' activities include:

- HMO's send infection information every time a surgery is performed.
- Hospitals and surgical centers provide information to the patients when they enter for surgery.
- Signs/Stickers regarding handwashing are posted.
- Long Island ran a poster contest.
- Some states pair an advocate with each hospital to work with CEO's.
- Utah invented "germ glow" which when applied to the hands, and objects are touched, the areas touched (germs) will show with a special light.

Public Education campaign:

- A sub-committee was formed to research the benefits of a public education campaign. The sub-committee consists of: Jean Rexford, Bonnie Capasso, Julie Petrellis, Jennifer Martin, Sue MacArthur and Jennifer Barrows.
- The sub-committee will look into available literature, creating a logo to be utilized on the CT literature to create a consistent message

Discussion took place regarding active surveillance the following information was provided:

- Include active surveillance with the public reporting (NJ, MD and IL publish which hospitals do active surveillance)
- Create an internal document that provides additional information about infections for hospital staff not to be shared with the patients.
- Consider eliminating shaving of surgical sites.
- Confidential exit survey of the patients asking if they had an infection. Information utilized for internal use only and will not be published, will be in aggregate format only.
- Hold a monthly event regarding infections by using the local boards of health websites and grand rounds at hospitals to educate the health care consumer and partner with the hospitals.

The 3rd week in October is national infection control week. This is an opportunity to showcase or kick off infection control efforts.

The best practices sub-committee of the Quality in Health Care Committee is working on the following endeavor:

- Provide a message to the public regarding hand washing possibly utilizing the following methods:
    - Contests regarding a logo
    - Public Service Announcements
    - Patient involvement by having them ask the health care staff if they washed their hands prior to examining them.
    - Giving patients a sign they can wave that asks staff whether they washed their hands.
    - In order for this to move forward, everyone needs to be involved including patients, staff and doctors.
- Wendy Furniss will share minutes from the Quality in Health Care meetings via e-mail to keep the workgroup informed of their efforts.

CT Hospitals projects:

- A Pilot program is starting soon at Yale that includes engaging staff and patients in infection control measures.
- St Raphaels has created a "sharing of care" program that has nurses educating patients to ask health care workers to wash their hands. Some of the patients have been embarrassed or uncomfortable asking.
- UCONN Health Center has created the "just ask" campaign. Patients wear badges that remind them to ask if health care workers have washed their hands.

CT Hospital needs:

- NHSN - The software for NSHN is free and requirements of the system are listed on the website. Major cost to facilities is paying a person to learn the system.
- DPH will put together a budget request to submit through the proper channels, which will include enhanced education for housekeeping staff and medical personnel.
- The workgroup will review the national data available regarding the expense of patients having an infection vs. savings for education and prevention.

Methods of awareness:

- Need to discuss education campaign for hospital cleaning and non-medical staff focusing on high touch areas.
- Most hospitals only spend 12-18 minutes per room cleaning each day (extra time if the patient is discharged)
- Many hospitals make cuts to the housekeeping budget first when they experience budget issues.
- Non-sterilized equipment such as IV poles, blood pressure cuffs, wheel chairs and stretchers should not be shared.
- Possible future recommendation: Establish a mandate through DPH for each health care facility to obtain a dedicated infection control person to monitor and enforce a minimum standard. The workgroup would need to develop the minimum standards. One standard noted: 1 infection control personnel per 100 patients.
- Identify a surveillance and data collection system using DPH as a conduit via the licensing process. The quest for the first year:
    - Use catheter related blood stream infections as a pilot because it is the most costly and there are evidence-based interventions that can be utilized for prevention.

- Help hospitals get digital certifications for the NHSN (some already have, a survey needs to be completed to find out which need help)

Report:

- Begin drafting report. Once completed a copy will be sent via e-mail for comments from the workgroup.
- A component should be added to the report including future actions the workgroup may want to take: include ambulatory surgical centers along with the hospitals, and recommend the workgroup or a variation of the workgroup continue to meet to ensure continuity.

The next meeting is taking place on March 16, 2007

The meeting adjourned at 11:00 am.

BEST PRACTICES SUBCOMMITTE MINUTES
FEBRUARY 21, 2007

Present: Julie Petrellis, Diane Smith, Bonnie Capasso, Jon Olson, Kimberly Skehan, Julie Moy
Guests: William Rifkin MD, Norma Gyle Dep. Commissioner DPH

Addendum

Diane Smith called the **meeting to order at 1:10 PM**.

The **minutes** of January 2007 meeting were accepted. Crystal Jeter's name was misspelled.

Handouts were available from the National Patient Safety Foundation announcement of the National Patient Safety Awareness week - March 4 – 10, 2007, and
"Abstract – Creation of Public Health Infection Prevention Messages in Connecticut Hospitals"

Health Messaging – Julie Petrellis presented Crystal Jeter's abstract on hand washing which suggested health messaging programs to improve community awareness of hand washing and respiratory etiquette. A survey was completed by classmates, church members and CHA employees regarding their knowledge about hand washing. The survey indicated that people do not read and are not interested in handouts.
Discussion continued regarding reaching the public and educating them to change the need to sneeze and/or cough in their sleeve.

- The benefit of hand gels, displaying them in the facilities.
- How hand gel is an acceptable substitute for hand washing unless hands are visible dirty.

Dr. Rifkin mentioned hand washing with soap and water was needed when caring for patients with open sores and C. difficile, which is becoming a growing problem in hospitals.
Diane Smith suggested using inserts for information with state employees paychecks, as we did with the wallet medication cards.
Dr. Gyle commented that the public rarely keeps inserts.
Bonnie Capasso suggested using billboards.
Julie Pretellis agreed that billboards and public service announcements (PSA) were good and that Crystal Jeter's next project will include gathering information on their use.
Dr. Rifkin commented on hospitals having difficulty with the clinicians and to get patients to observe providers using hand-washing procedures and then address those clinicians that are not following hand-washing procedures.
Julie Pretrellis said that there was a need to get patients to ask providers "did you wash your hands". Everyone needs to work together to get this message out. Discussion pursued on how to get this message out, e.g., posting signs, buttons with the logo "did you wash your hands".
Jon Olson suggested that a pennant be given to patients with a logo to remind providers of hand washing. For those patients that are comatose the pendant could be placed on the bed frame.
There was further discussion on billboards and marketing costs, but since health care providers and insurance companies already use billboards, there may be a way to use them to advertise hand hygiene.
Dr. Rifkin suggested having a marketing survey, patient reporting physician hand washing.

Bonnie Capasso suggested that CHA have a contest to get a symbol/logo for the hand hygiene project.
Dr. Rifkin said that for Waterbury Hospital it could be “Waterbury Hospital, we wash hands”.

ASSIGNMENTS: Julie Pretrellis offered Crystal Jeter to explore the billboards.
Dr. Rifkin will investigate the cost effectiveness for billboard use.

Next meeting date: March 21, 2007 at CHA at 1 – 3 PM.

Meeting adjourned at 2:45 PM.