Carrot or stick? Building capacity in ASP and infection control through quality accreditation

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APEC

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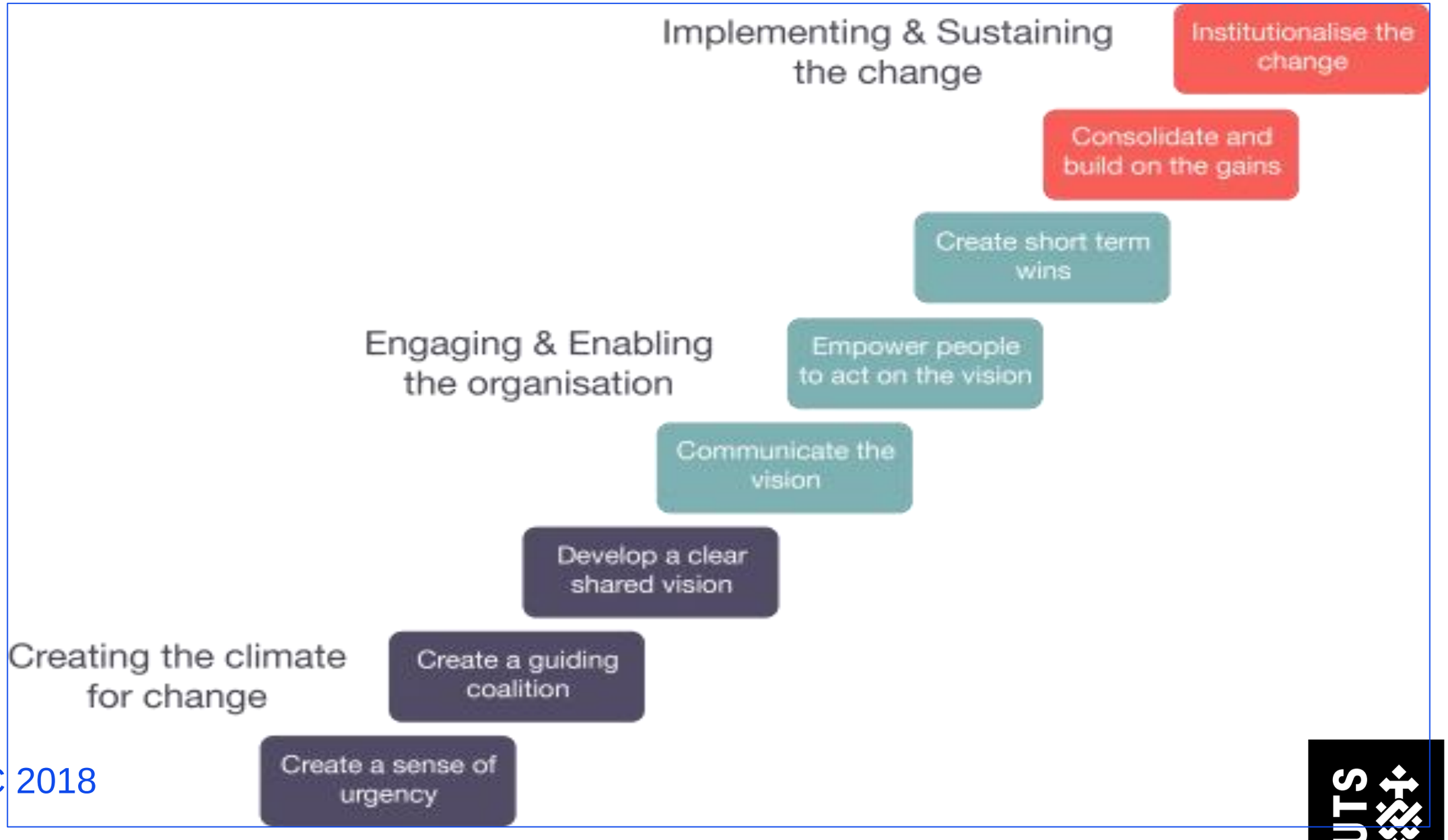
Where to start?

The phrase "**carrot** and **stick**" is a metaphor for the use of a combination of reward and punishment to induce a desired behaviour. It is based on the idea that a cart driver might activate a reluctant horse by dangling a **carrot** in front of it and smacking it on the rear with a **stick**.

The carrots

Kotter's 8-step change model



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urgency

stakeholders

vision

communicating the vision

short term wins

consolidating

institutionalise

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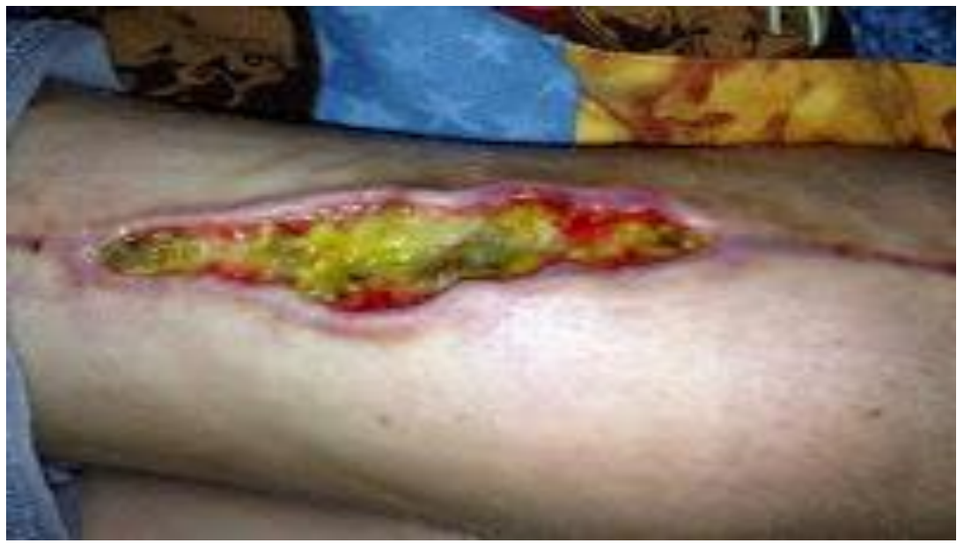
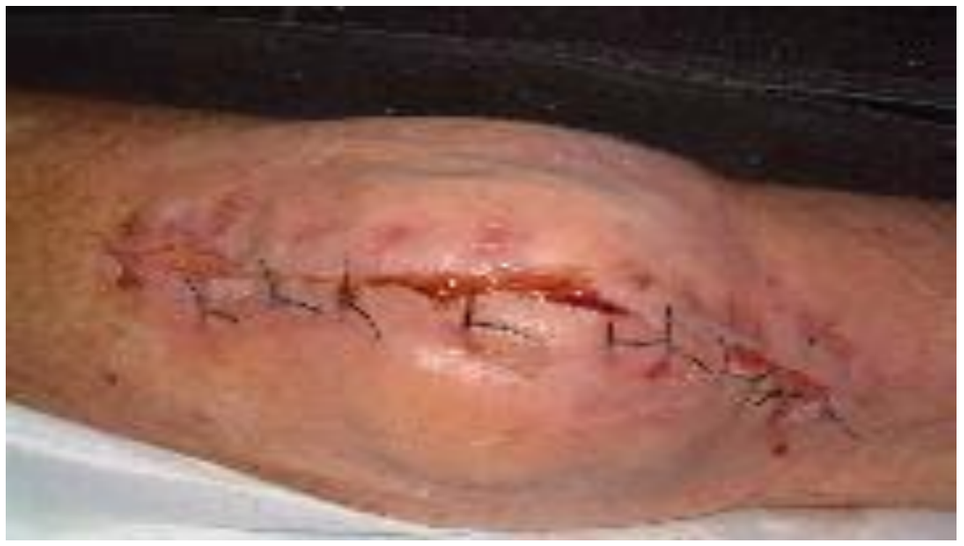
Do HAI matter?

Pain, suffering and possible death for patients

More work for health staff

Increase LOS, costs, available beds etc





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Who is at risk of HAI?

The old

The young

The very sick

Patients who have had surgery

Patients with IV lines

Patients with drains

Patients who are immunocompromised

Patients with central lines, dialysis catheters

Patients with urinary catheters

Patients with increased LOS

Patients with co-morbidities

Where to start?

Priorities:

Quick wins

Unify professionals – voice, action,

Bring 8 jurisdictions on board – save time and $$$

Standardisation

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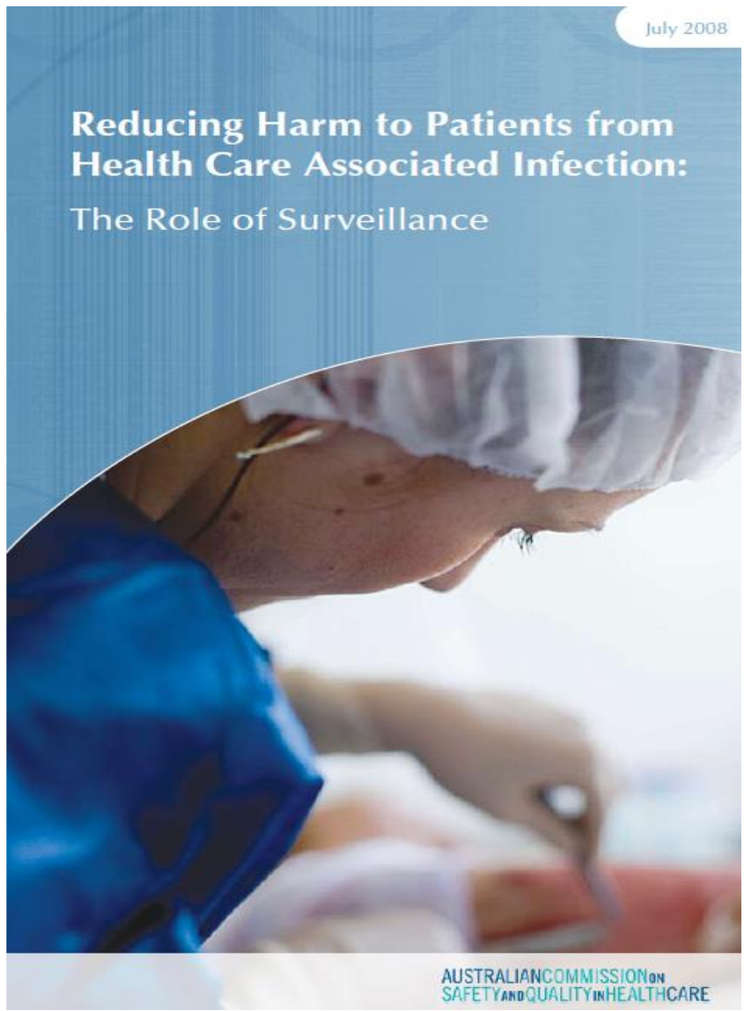
Initial (small) steps in national HAI Surveillance



- 51 co-authors
- (limited) recommendations from experts
- top 3
  - surveillance
  - hand hygiene
  - infection control guidelines

endorsed by health ministers

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Putting good practice into policy and good policy into practice

What should a national program look like?

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Engaging with experts – Implementation Advisory Committee

The committee brought clinical, academic, professional, research and government expertise with geographical representation across Australia:

Think national!!

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National data

Only from large data sets can decisions be made on some HAI measures.

- local and state surveillance data bases do not contain sufficient data to reliably plot trends eg antimicrobial usage
- to inform and update infection control guidelines, national programs
- guide national policy and priorities
- monitor national trends

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AAA Infections Audit Annually,
Additional Isolation Precautions,
Additional Precautions Audit
Aged care infection control practice audits,
air sampling in theatre
all clinical areas.
Antibiotic prophylaxis
BBSE cause & effect
Blood and Body F
Blood fridge,
Care of patient eq
central devices
central IV access
central line
CJD questionnaire
Clinical Audits
Clinical waste & s
Clinical waste ma
Cold chain,
Correct waste disp
customer focus su
Decubitus Ulcers
Drinking water
Education Attenda
Engineering and E
engineering,
Environment,
Environmental &
environmental all
Environmental Au
Environmental Hy
Environmental sw
environmental/house keeping audit
equipment e.g. IV pumps.
Equipment Reprocessing Annually
Eye Infections and
flash steriliser use in theatres;
flash steriliser,
food handling,
Food safe
food safe program
food services,
Food storage,
Food temperature.
Fridge temp record immunisatios
Fridge temperatures monitored
Gastroscopes (GESA guidelines),
general infection control audit
glutaraldehyde management
GOR/CSD/

hand hygiene compliance
competency
Hand hygiene solution audit by company rep
hand hygiene station audit,
hand washing audit

Hand washing knowledge audit;
Iso
IV
IV
IV
IV
IV
IV
Kit
EM
kit
Le
Legionella tower testing;
Legionella water testing of patient/staff use areas legionnaire
H20 testing 3 monthly
linen,
maintenance
mask fit testing annually

mortuary audit;
motor vehicle audit,
MRO compliance audits
MRO documentation audits
MRO,
MRSA audits
MRSA documentation
N95/P2 fir checking competency
needle stick body fluid,

mpliance;
monthly,
compliance

cts

of aged care

twice year,
policy compliance
Post Body Fluids Audit annually
PPE audit
PPE Availability Audits 3 monthly,
PPE compliance audits
PPE Compliance.

in clinical areas annually
PPE knowledge/donning & doffing assessment;
processsing of equipment.
proper disposal of waste
RADIOLOGY,
Rain water (Dialysis),
Rain water (drinking),

scope cleaning
Sharp disposal
sharps
Sharps and clinical waste management
sharps and sharps containers.
Sharps Audit
sharps bins audits.
sharps compliance,
Sharps container audit
Sharps containers: audit disposal practices and safety
sharps control
Sharps disposal
Sharps information audit
sharps management,
sharps safety & biohazard injuries
sharps safety,

site audit annually
specimen collection
SSI audit,
SSI prophylaxis
staff compliance to uniform i.e. jewellery, hair, nails
staff immunisation audit,
staff knowledge of infection control standard & additional precautions ,
Standard precautions compliance;

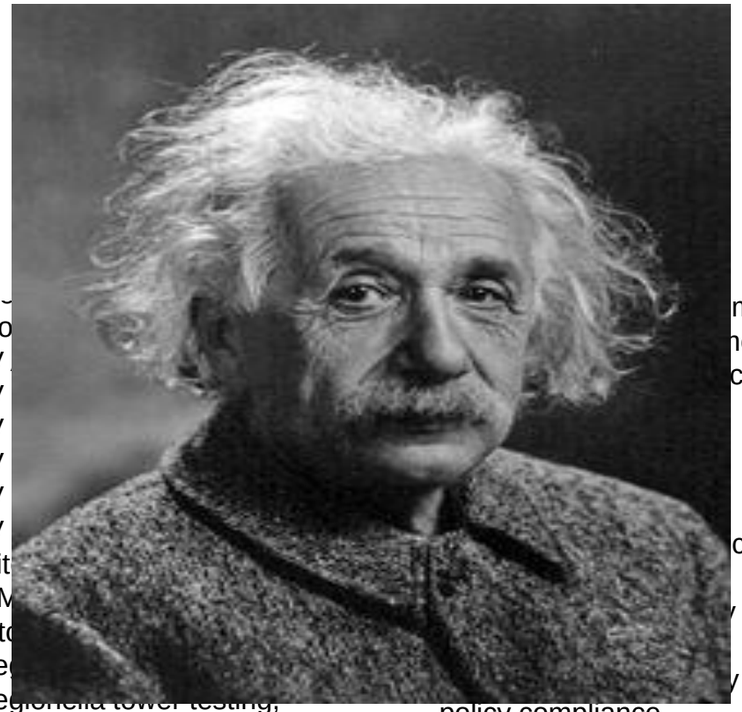
Ward/Department based IC audits (all principles audited),
warm water
Warm water / Legionella
waste
Waste Compliance;
Waste disposal,
Waste management
WASTE,
water testing
Wound Drains

"Not everything that can be counted counts,

and

not everything that counts can be counted"

Albert Einstein



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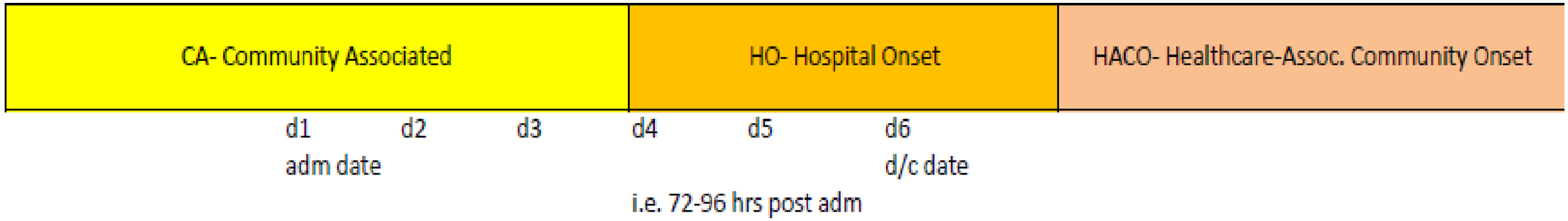
es, hand

Infections – what are healthcare associated infections (HAI)?

- Infections patients get as the result of health care



Primary category			Codes	
CA	No admission within 365 days	Subclassify	CA	
	Was not admitted from residential care address		CA-OS	Where overseas exposure recorded within previous 6 months
HO		Subclassify	HO-HNE	HNE LHD hospital onset
			HO-nonHNE	Non-HNE LHD hospital onset
HACO	ONE or more of:	Subclassify	HACO-HNE	Specify HNE LHD hospital that was the last prior location
	Admission within 365 days		HACO-nonHNE	Specify non-HNE hospital that was the last prior location
	Residential care resident at time of detection		HACO-OS	Where HACO exposure(s) were in a foreign location without more recent hospital exposure

HNE= Hunter New England Local Health District

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Need for standardisation

National Cumulative Hospital Antibiogram

Standardisation of laboratory reporting

Second National Survey of Clostridium Difficile Infection (CDI)

Antibioti

Antimicr

National

Multi Resistant Gram Negative (MRGN) Taskforce

HAI Technical Working Group

National safety and quality health service standards

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“Flexible standardisation”

Aims for AMS Forum

Snapshot of current state of AMS across Australia

Be inspired by examples of successful/innovative programs

What are the likely barriers to implementing the recommendations?

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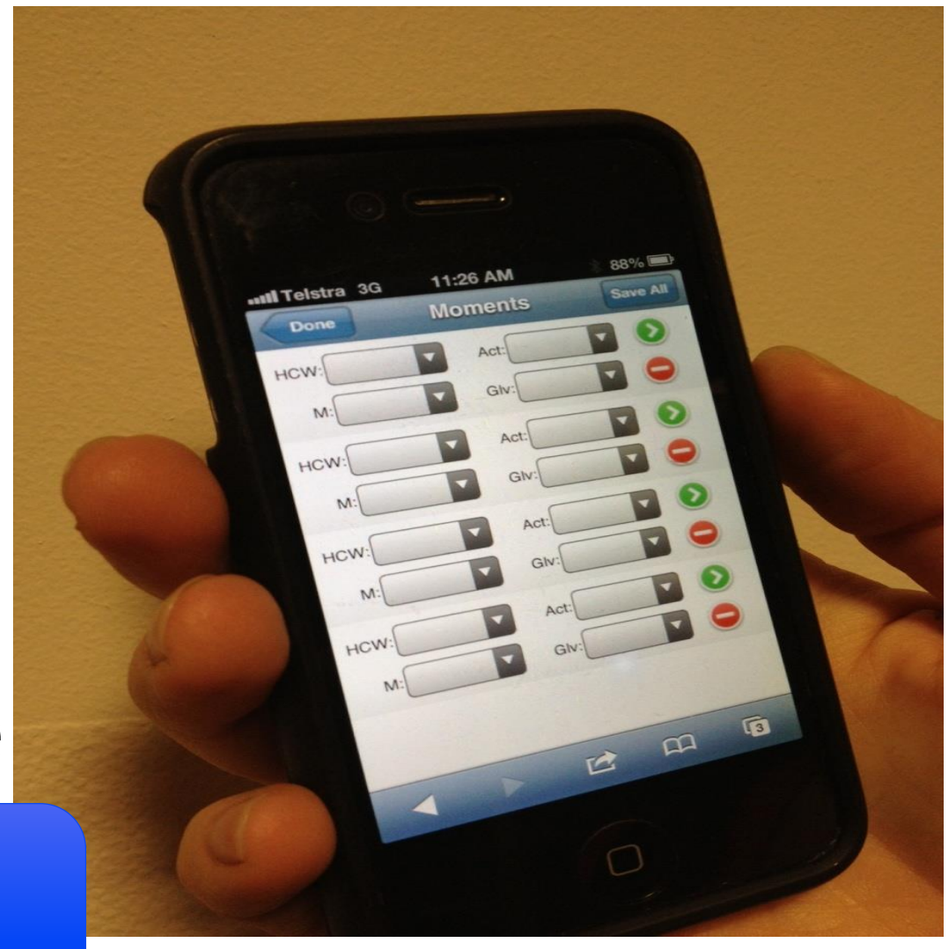
Making change easy - Collection by HHApp

Central HH database

New direct-entry HH compliance App

- i-Phones, other Smartphones
- Benefits:
- Reduces data management time by 50%
- No duplicate data entry and errors
- Potential – WHO, NZ, Singapore



Platform and database - potentially huge

I’m here to help!

The Clinical Care Standard for AMS

Implementation happens at the bedside

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Infection Control Guidelines

Australian Guidelines for the Prevention and Control of Infection in Healthcare based on:

- Best available current scientific evidence
- International guidelines (CDC, EPIC II)
- Best practice / expert opinion

Guidelines don’t implement themselves

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AMS in different settings

Table 2 provides suggestions for ways in which strategies to support antimicrobial stewardship (AMS) r implemented in different settings.

Table 2: Options for implementation of antimicrobial stewardship in different facilities

Program elements	Health service organisation (e.g. Local Hospital Network/district or private hospital organisation)	Large urban hosp tertiary facility (large private hos	Other or rural/district hospital	Small hospital/multi-purpose service (MPS) (less than 50 beds)	Day surgery/procedure unit or services
Executive leadership	Network/district/management group executive sponsorship and support for AMS program	Local executive spon support for AMS pro	Local executive sponsorship and support for AMS program	Local executive sponsorship and support for AMS program	Owner/management support for AMS program
Governance arrangements, structure and lines of communication	Director of AMS program and multidisciplinary AMS committee comprising core representation of: ▪ a member of executive	Director of AMS prog pharmacist, infectiou physician or medical with	Pharmacist (where possible) When no pharmacist available a clinician/nurse with dedicated time for AMS coordinates with	Facility manager coordinates with input from local or network pharmacist, infectious diseases physician and medical	Facility manager coordinates, with support from specialist visiting clinicians and/or pharmacist where available s to committees responsible gs and therapeutics
AMS team					ty manager, nurse and g medical officer (surgeon aesthetic representative or macist where available)
Antimicrobial policy with defined components	is endorsed by network/ district/management group executive and roles and responsibilities defined	endorsed by senii and management and responsibilitie ▪ May be developec implemented loca part of higher leve	district-wide approach to outline scope of program	network/district-wide approach to outline scope of program	Preferably determined/ developed/initiated and overseen by broader organisational management ▪ Policy specifies agreed local approach to surgical prophylaxis

(Table continued next page)

One size does not fit all

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Rural and regional hospitals

About 1/3 of hospitals in Australia are < 20 beds

Depend on GP visiting medical officers

Lack of access to ID physicians, clinical microbiology, pharmacists or pathology services

Lack of access to education and training

Difficulty in retaining experienced clinicians

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Private hospital sector

> 40% of all hospital care and > 60% of surgery

Limited scope to introduce restrictions, prescribing policies,

No inherent hierarchy in private hospitals – but some influence by peers

Doctors are the “customers”

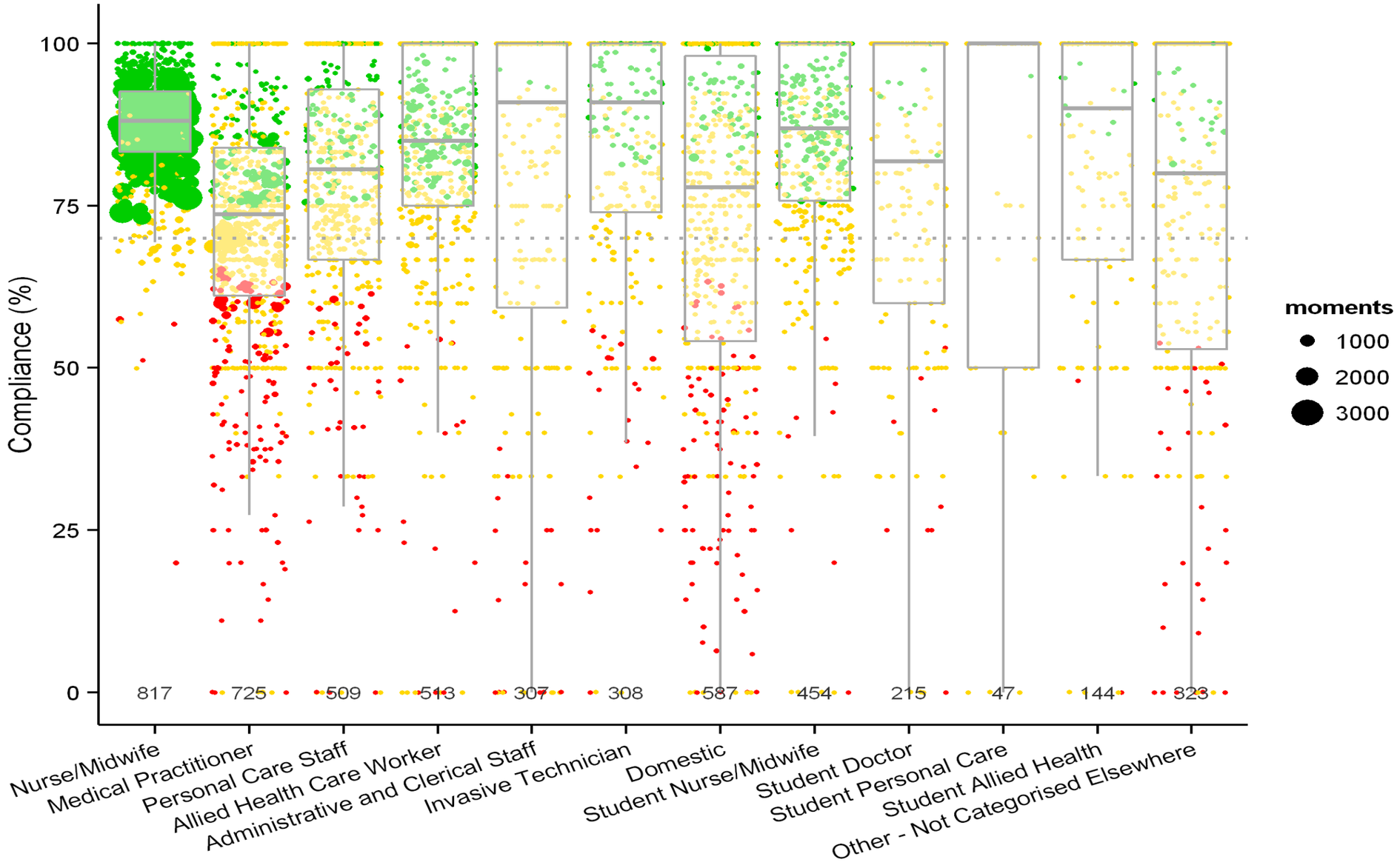
Nurses often follow doctors protocols rigidly

ID physicians involved at patient rather than hospital level

Doctor - Patient

Hospital ≠Patient

Hand Hygiene Performance: by Profession



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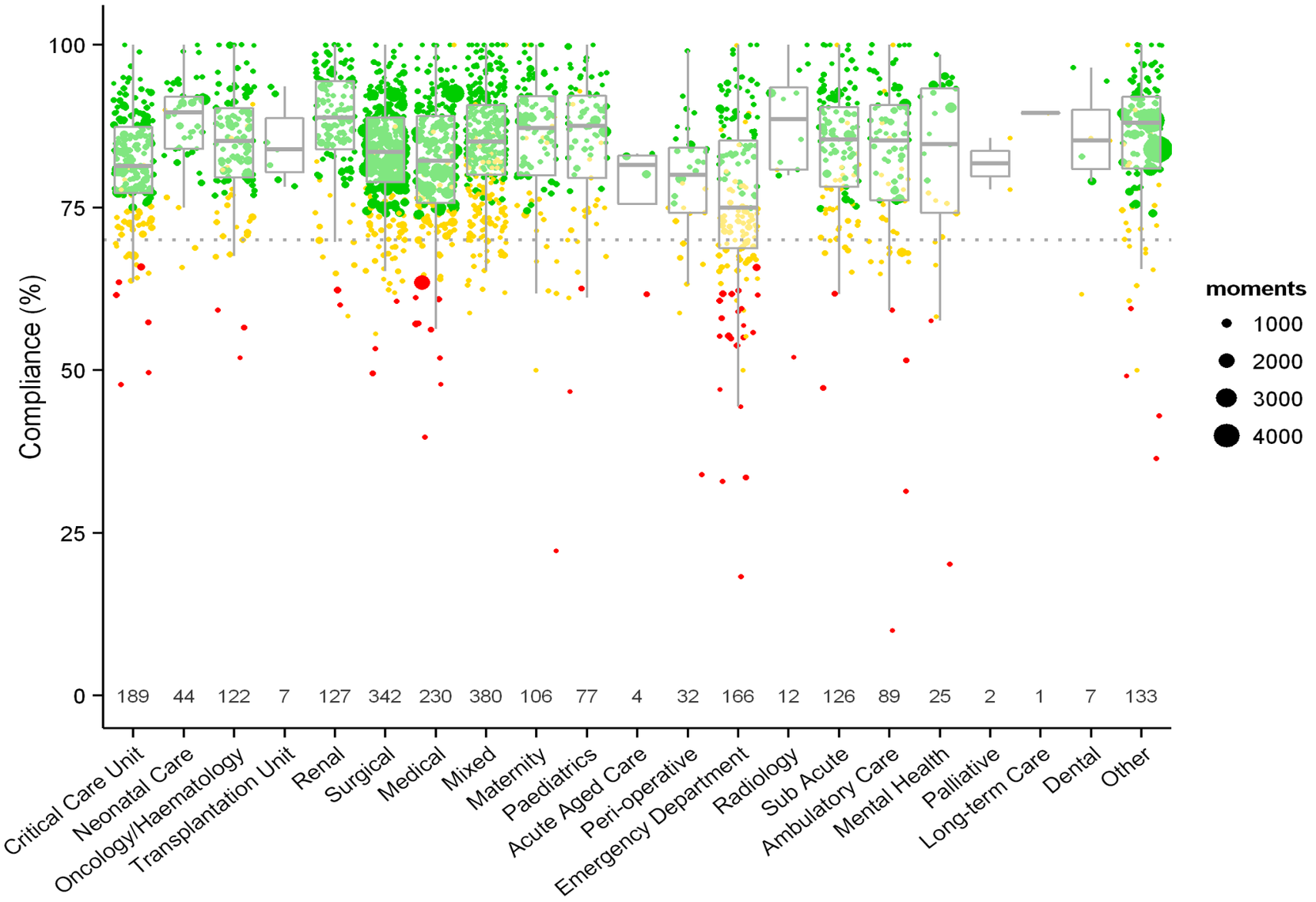
Hand Hygiene Performance: Department Type



The stick

Priorities for Standard 3

Having an effective governance framework

Identifying what is working well

Knowing your risks and/or gaps

Having systems to gather, review and report evidence

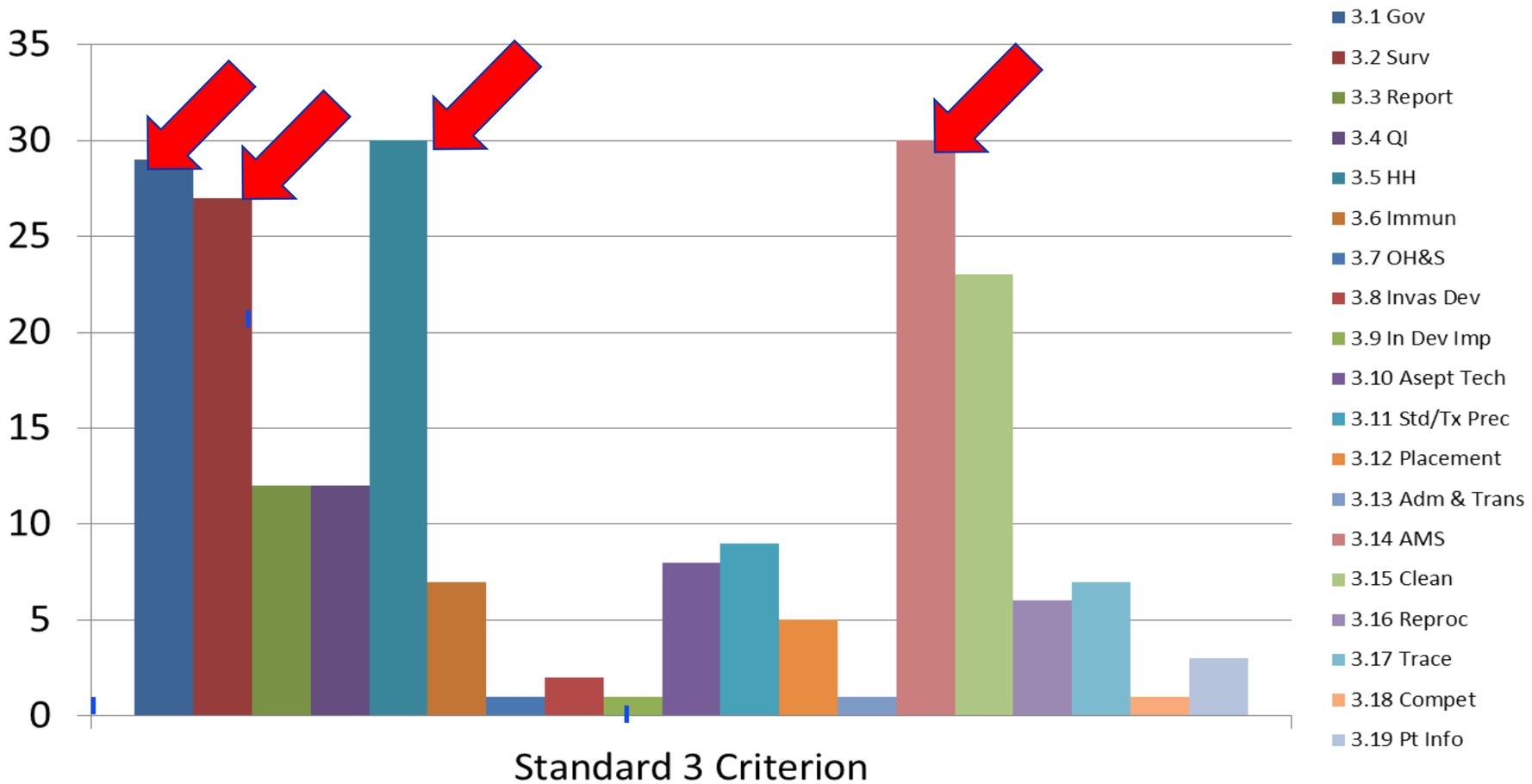
Having a plan to address risks and respond

Aiming for the best (either 0 or 100%)

Demonstrating progress/improvement

Engaging with others in the organisation

Met with Merit
Health service accreditation



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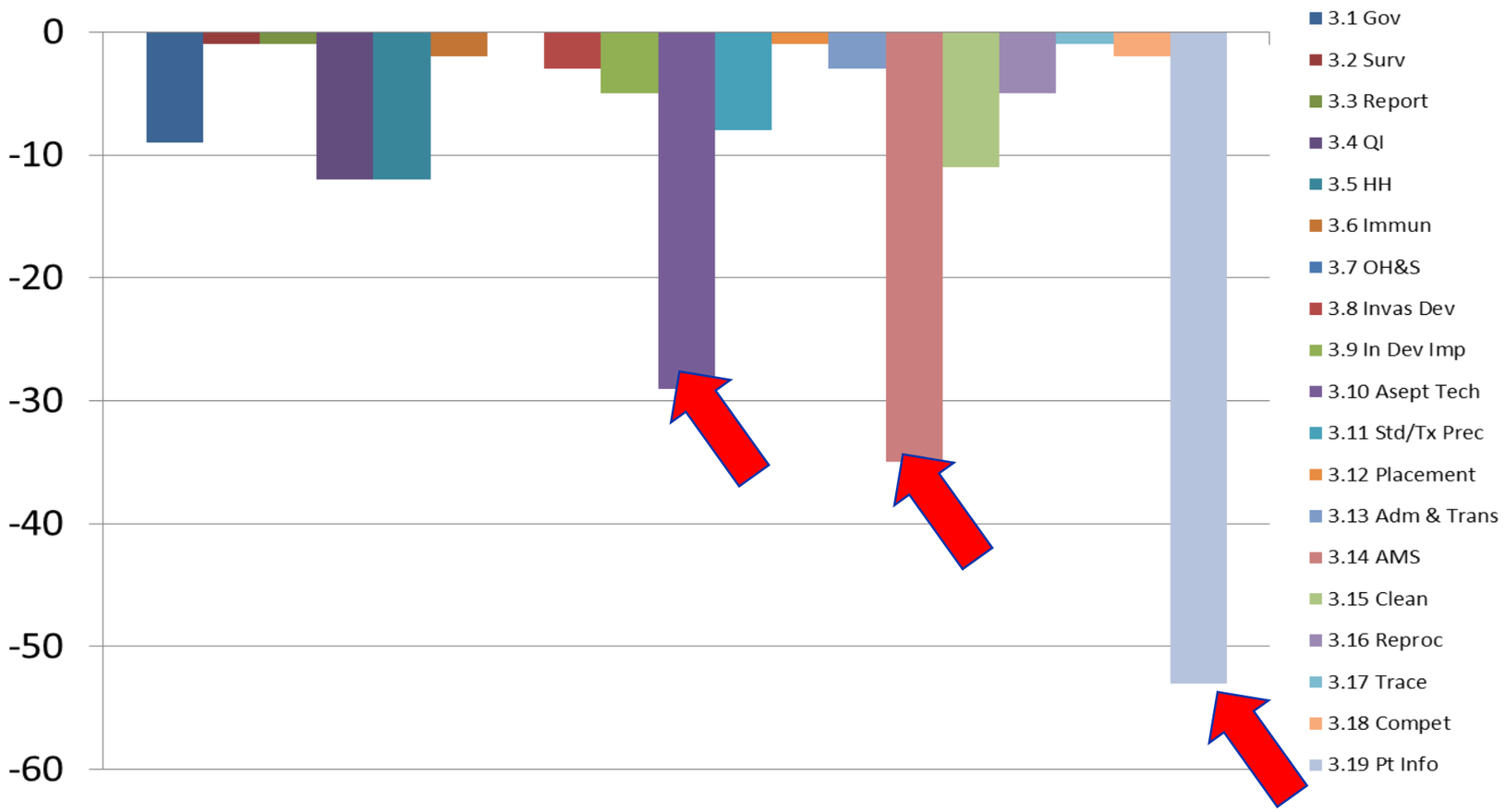
Not Met
Health service accreditation



March-December 2013

Steps to national roll out

It’s wasn’t easy!

- involve key stakeholders in design and implementation
- agreed organisational objectives
- use trained personnel to collect and manage data, and provide them with appropriate information technology support
- use definitions of surveillance events that are unambiguous, practical, specific and can be validated
- use reliable and practical methods for detecting events

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Thank you