Chasing Zero Infections Coaching Call
Strategies to Reduce Surgical Site Infections
March 14, 2018
Agenda

• Welcome & FHA Mission to Care HIIN Trends and Progress: Surgical Site Infections
  – Cheryl Love, RN, BSN, BS-HCA, MBA, LHRM, CPHRM, Director of Quality and Patient Safety and Improvement Advisor, FHA
• Coaching Call: Decreasing Surgical Site Infections
  – Linda R. Greene, RN, MPS, CIC, FAPIC, Manager of Infection Prevention, UR Highland Hospital, Rochester, NY
• Upcoming HIIN Events and Opportunities
• Evaluation & Continuing Nursing Education

Check the weekly MTC HIIN Upcoming Events for details and registration
HIIN Core Topics – Aim is 20% reduction

- Adverse Drug Events (ADE)
- Catheter-associated Urinary Tract Infections (CAUTI)
- Clostridium Difficile Infection (CDI)
- Central line-associated Blood Stream Infections (CLABSI)
- Injuries from Falls and Immobility
- Pressure Ulcers (PrU)
- Sepsis
- **Surgical Site Infections (SSI)**
- Venous Thromboembolisms (VTE)
- Ventilator Associated Events (VAE)
- Readmissions (12% reduction)
- Worker Safety
Raise your game: The UP Campaign

Cross cutting set of practices to better engage front-line staff without creating additional burdens
FHA SOAP UP Campaign
October 1 – December 31, 2017

- Handwashing is the single most effective way to reduce healthcare-acquired infections
- Handwashing is not new, but is a critical strategy
- Effective handwashing can prevent several harm events

http://www.fha.org/soapup
Progressive mobility preserves muscle strength, improves lower limb circulation and lung capacity, reduces length of stay and reduces delirium

Lack of mobility is most dangerous in the elderly but healthier patients are at risk as well

Improves multi-disciplinary collaboration and focus on preventing patient harm

Involves patients and families in the care plan

Impacts seven harm topics, saves lives and avoids costs

Key Message: Walk in, Walk during, Walk out!

http://www.fha.org/getup
Minimizing sedation allows for early mobilization, reducing delirium and respiratory compromise.

Over-sedation increases chance of harm and results in longer length of stay.

Monitoring reversal agents and emphasis on minimal sedation assists in the prevention of seven harm events.

http://www.fha.org/wakeup
FHA Mission to Care Update: Florida | SSI Rates

Source: HRET Comprehensive Data System, March 9, 2018
FHA Mission to Care Update: SSI - Colon

Source: HRET Comprehensive Data System, March 9, 2018
FHA Mission to Care Update:
SSI - Hysterectomy

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<th>Rate per 100</th>
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<th>O-16</th>
<th>N-16</th>
<th>D-16</th>
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Source: HRET Comprehensive Data System, March 9, 2018
FHA Mission to Care Update: SSI - Knee

Source: HRET Comprehensive Data System, March 9, 2018
FHA Mission to Care Update: SSI - Hip

Source: HRET Comprehensive Data System, March 9, 2018

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Effective Date: March 9, 2018

All measures calculated per 1,000 unless noted.
* Rate calculated per 100
** No multiplier

### Measure Rates

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<th>Average Rate</th>
<th>Progress</th>
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<td>10,765</td>
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<td>SSI rate, knee surgeries*</td>
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SSI Resources, Trainings and Tools


http://www.hret-hiin.org

- SSI Change Package
- SSI Top 10 Checklist
- SOAP UP Resources
- Watch Past Webinars
- HRET HIIN Resource Library
- Guides
- Case Studies
Coaching Call: Decreasing Surgical Site Infections

Linda R. Greene, RN, MPS, CIC
Manager, Infection Prevention
UR Highland Hospital
Rochester, NY
linda_greene@urmc.rochester.edu
Polling Question 1

What is your background?

1. SSI project leader
2. Quality/Safety specialist
3. Nurse leader
4. OR staff member
5. Infection Preventionist
6. Other
Current Burden

Burden (US)

- 160,000 - 300,000 SSIs per year
- 2-5% of patients undergoing inpatient surgery
- One of the most common and costly HAIs

Mortality

- 2-11 fold higher risk of death
- Length of stay
- 7-11 additional post-op days
Burden

- Cost $3.5 - $10 Billion annually
- Estimated cost per infection ranges from $11,000 - $35,000
- Colon and hysterectomy contribute to HAC reduction and Value Based Purchasing
- Contribute to 30 day unplanned readmissions
Compared to a previous survey conducted in 2011, in which approximately 4 percent of patients had at least one HAI, data from the survey conducted in 2015 showed that the proportion of patients with HAIs was significantly lower, at approximately 3.2 percent.

This was largely due to decreases in surgical site infections and urinary tract infections,” said Magill.
Data

17 percent decrease in surgical site infections (SSI) related to the 10 select procedures tracked in previous reports

- 17 percent decrease in abdominal hysterectomy SSI between 2008 and 2014
- 2 percent decrease in colon surgery SSI between 2008 and 2014

Changes in SSI

Figure 10. Changes over time in abdominal hysterectomy SSI SIR in US hospitals using 2006-8 baseline, NHSN 2010-2016
Polling Question 2

What is the status of your SSIs in 2017?

1. Decreased
2. Increased
3. Depends upon the procedure
Discussion
Etiology

Surgical Site Infections can be attributed to the patient’s own endogenous flora or from exogenous sources.

Example:

- Patient’s skin
- Contamination during surgery
- Oropharyngeal contamination
- Patient’s natural immunity
Etiology

Exogenous sources:

- Hands of care givers
- Exposure to non sterile environment
- Contamination of fluid, supplies or equipment
- Air flow
Observations

- All surgical wounds are contaminated by bacteria but only a few get infected
- Different operations have different inoculums of bacteria
- Similar operations performed by the same surgeon in different populations have different rates of infection
- SSIs have varying degrees of severity
Bacteria Get into Wounds

Where are the Pathogens?

Pathogen source for most SSIs is endogenous flora of the patient’s skin, mucous membranes or GI tract.

20% of the skin’s pathogens live beneath the epidermal layer in hair follicles and sebaceous glands.

Any incision can carry some of the bacteria directly to the operative site.
Challenges

- Time
- Turnover

- Surgeon preference
- Adherence factors
Polling Question 3

What is your greatest challenge?

1. Compliance with guidelines
2. Turnover and pace
3. Engagement – staff and physician
4. Lack of standardization
Discussion
Leading SSI Pathogens

Gram positive bacteria
- MRSA
- MSSA
- Coagulase negative staphylococci
- Streptococcus species
- Enterococcus species

Gram negative bacteria
- Enterobacter
- Pseudomonas aeruginosa

Other pathogens
- Anaerobic bacteria
- Fungi
- Polymicrobial

Risk Factors for SSIs

Host Factors
- Obesity
- Age
- ASA
- Cancer
- Immunosuppression

Microbial Flora
- Nasal Carriage
- Virulence
- Inoculum

Surgical/Environmental Factors
- Procedure
- Hair Removal
- Prophylaxis
- Technique
- Contamination
- Urgency
**SSIs**

Majority of SSIs are seeded at the time of surgery while the wound is open examples:

<table>
<thead>
<tr>
<th>Microorganisms</th>
<th>Examples</th>
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</thead>
<tbody>
<tr>
<td>Patients own skin flora</td>
<td>Microorganisms colonizing skin or other body parts, infection present</td>
</tr>
<tr>
<td>Surgical Team</td>
<td>Colonized member of team</td>
</tr>
<tr>
<td>Breaks in aseptic technique</td>
<td>Wound contact with unsterile environment</td>
</tr>
<tr>
<td>Sterility failures</td>
<td>High bioburden. Contaminated instruments</td>
</tr>
<tr>
<td>Door openings</td>
<td>Interruption of positive pressure</td>
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<tr>
<td>Other endogenous flora</td>
<td>Bowel flora, etc.</td>
</tr>
</tbody>
</table>
Centers for Disease Control and Prevention Guideline for the Prevention of Surgical Site Infection, 2017

Sandra I. Berrios-Torres, MD; Craig A. Umscheid, MD, MSCE; Dale W. Bratzler, DO, MPH; Brian Leas, MA, MS; Erin C. Stone, MA; Rachel R. Kelz, MD, MSCE; Caroline E. Reinke, MD, MSHP; Sherry Morgan, RN, MLS, PhD; Joseph S. Solomkin, MD; John E. Mazuski, MD, PhD; E. Patchen Dellinger, MD; Kamal M. F. Itani, MD; Ellie F. Berbari, MD; John Segreti, MD; Javad Parviz, MD; Joan Blanchard, MSS, BSN, RN, CNOR, CIC; George Allen, PhD, CIC, CNOR; Jan A. J. W. Kuytmans, MD; Rodney Donlan, PhD; William P. Schecter, MD; for the Healthcare Infection Control Practices Advisory Committee

**IMPORTANCE** The human and financial costs of treating surgical site infections (SSIs) are increasing. The number of surgical procedures performed in the United States continues to rise, and surgical patients are initially seen with increasingly complex comorbidities. It is estimated that approximately half of SSIs are deemed preventable using evidence-based strategies.

Published online May 3, 2017.*
• **Category IA.** Strongly recommended for implementation and strongly supported by well-designed experimental, clinical, or epidemiologic studies.

• **Category IB.** Strongly recommended for implementation and supported by some experimental, clinical, or epidemiologic studies and a strong theoretical rationale; or an accepted practice (e.g., aseptic technique) supported by limited evidence.

• **Category IC.** Required by state or federal regulations, rules, or standards.

• **Category II.** Suggested for implementation and supported by suggestive clinical or epidemiologic studies or a theoretical rationale.

• **Unresolved issue.** Represents an unresolved issue for which evidence is insufficient or no consensus regarding efficacy exists.
Polling Question 4

Did you do a gap analysis to assess compliance with the HICPAC Guidelines?

Yes

No
GAP Analysis

CDC GUIDELINE FOR THE PREVENTION OF SSI, 2017

Current Bundle: A strategy to address the recommendation is currently incorporated into the SSI Bundle for that service. (Y/N)
Current Performance: Current performance for that strategy is at or better than target (Y/N).

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<tbody>
<tr>
<td>Parenteral Antimicrobial Prophylaxis</td>
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<tr>
<td>1A.1 Administer preoperative antimicrobial agents only when indicated based on published CPG and time such that a bactericidal concentration of the agents is established in the serum and tissues when the incision is made.</td>
<td>IB</td>
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<tr>
<td>1B Administer the appropriate parenteral prophylactic antimicrobial agents before skin incision in all cesarean section procedures.</td>
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<tr>
<td>1C Weight-adjusted parenteral antimicrobial prophylaxis dosing</td>
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<tr>
<td>Other guidelines: CPG’s based on a review of the evidence and expert opinion recommend increasing the single preoperative prophylactic antimicrobial agent dose for select prophylactic antimicrobial agents in obese and morbidly obese patients. For cefazolin, recommendations are to administer 2.0 g for patients weighing &gt;60-80 kg and 3.0 g if &gt;120 kg. For ampicillin/sulbactam, dosing is calculated using the patient’s ideal body weight plus 40% of the difference between the actual and ideal body weight. Vancomycin should be dosed at 1.5 mg./kg.</td>
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<td>No rec.</td>
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<td>1D Intraoperative re-dosing of parenteral prophylactic antimicrobial agents</td>
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<tr>
<td>Other guidelines: CPG’s based on a review of the evidence and expert opinion recommend prophylactic antimicrobial agent re-dosing in cases of prolonged procedures (when the procedure exceeds the half-life of the prophylactic antimicrobial agent or is longer than 3-4 hours and in patients with major blood loss (&gt;1500 ml) or extensive burns. Redosing should also be performed at intervals of 3-2 times the prophylactic antimicrobial half-life, starting at the beginning of the preoperative dose. No recommendations are provided for optimal prophylactic antimicrobial agent dosing in obese/morbidly obese patients when re-dosing.</td>
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<td>1E In clean/clean-contaminated procedures, do not administer additional prophylactic antimicrobial agent doses after the surgical incision is closed in the OR, even in the presence of a drain</td>
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Discussion- Where Are Your Gaps?
## Selected Elements of Surgical Care Bundle from Literature

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<th>Element</th>
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<tr>
<td>Appropriate antimicrobial prophylaxis</td>
<td>Antimicrobial (triclosan) sutures</td>
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<td>Weight-based dosing</td>
<td>Smoking cessation</td>
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<tr>
<td>Glycemic control</td>
<td>Staphylococcal surveillance (cardiothoracic and orthopedic procedures)</td>
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<tr>
<td>Normothermia</td>
<td>Oral antibiotics plus mechanical bowel preparation (colorectal)</td>
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<tr>
<td>Appropriate hair removal</td>
<td>Minimally invasive surgery</td>
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<tr>
<td>Supplemental $O_2$ (colorectal procedures)</td>
<td>Short duration of surgery</td>
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<tr>
<td>Use of wound edge protectors</td>
<td>Glove change prior to fascia and skin closure</td>
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<tr>
<td>Dedicated wound closure tray for fascia and skin</td>
<td>Limit traffic in the operating room</td>
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<td>Pre-operative 4% CHG shower or 2% CHG cleansing</td>
<td>CHG cleansing of surgical wound</td>
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<tr>
<td>70% alcohol with 2% CHG perioperative skin preparation</td>
<td>Keep sterile dressing intact for first 48 hours</td>
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https://www.dhs.wisconsin.gov/hai/ssi-prevention.htm
Strategies to Prevent SSIs

You must consider whether any given risk is:

**Modifiable:**

i.e. glucose, antimicrobial administration, hair removal

**Non Modifiable:**

i.e. age, co-morbidities, severity of illness, wound class
Colorectal Bundle

Intraoperative

1. Hair Removal
   - Hair removal (only if hair will interfere with the operation) with clippers, outside the OR if at all possible

2. Antibiotics
   - Redose prophylactic antibiotic based on duration of operation

3. Skin Prep
   - Use standardized antiseptic agent for skin prep: alcohol-containing (Chloroprep, Duraprep) unless contraindicated (infants, mucous membranes, ear procedures, open wound)
   - When alcohol-based skin prep is contraindicated, use Chlorhexidine or Povidone Iodine antiseptic agent for skin prep. Regardless of antiseptic agent used, it must be allowed to dry completely. Alcohol prep would be contraindicated for use for during emergent cases with no drying time

4. Hand Hygiene & Asepsis
   - Ensure double gloving/sterile gloves for all scrubbed surgical team members
   - Keep nails short, do not wear artificial nails or hand or arm jewelry
   - Clean underneath fingernails prior to first daily surgical scrub
   - Follow policy: Surgical/Procedural Hand Hygiene
   - Wear disposable cap or hood to fully cover head/facial hair and surgical mask to cover nose/mouth when entering the operating room and until the conclusion of the operation
   - Use surgical gown and drapes that are liquid resistant
   - Change surgical scrubs if visibly soiled or contaminated

5. Temperature
   - Maintain perioperative normothermia (≥ 36°C)
   - Use of Bair Hugger.
   - Warm IV fluids
   - Follow policy: Maintaining Normothermia in the Surgical Patient

6. Drains
   - If drainage is indicated, use a closed suction drain placed through a separate incision
   - Remove drain as soon as possible
   - Do not continue prophylactic antibiotics because drains are in place

7. Items intentionally left in patient
   - Document items left behind in operative notes (stents, packing, drains, etc)
   - Document plan for removal if item is temporary

8. Surgical Technique
   - Use of wound protectors
   - Change gloves prior to closing
   - Use of clean instruments (Colorectal Closing Set) for closing of the wound
Polling Question 5

Do you use bundles or pathways?

1. Yes
2. No
Polling Question 6

Do you monitor compliance to bundles or pathways?

1. Yes
2. No
3. Do not use
Given the complexities inherent in translating evidence into practice, evidence-based practices are unfortunately not necessarily immediately applied in patient care settings.

Studies suggest that certain infection prevention practices are not commonly used in some hospitals, even with evidence demonstrating that these practices substantially reduce infection risk.

“While most hospitals have policies in place to prevent health care-associated infections, clinicians often fail to follow evidence-based guidelines established to prevent these infections.”

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Discussion and Questions
# Chasing Zero Infections Series

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<th>Access Event Archive: Recording</th>
<th>Slides</th>
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<td>Jan. 17, 2018</td>
<td>Didactic Webinar</td>
<td>Reducing Infections with Ventilator Associated Events (IVAC)</td>
<td><a href="#">Access Event Archive: Recording</a></td>
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<td>Strategies to Reduce Surgical Site Infections (SSI)</td>
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<td>Apr. 10, 2018</td>
<td>Interactive Coaching Call</td>
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<td>Interactive Coaching Call</td>
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Check the weekly **MTC HIIN Upcoming Events** for details and registration

Email **HIIN@fha.org** to request an archived webinar
IP Boot Camp

• Date: March 22-23, 2018
• Location: FHA Corporate Office, Orlando
• Program:
  – Led by Linda Greene, RN, MPS, CIC, FAPIC
  – Professional development of novice infection preventionists new to their role (less than 2 years)
  – Focus on fundamental knowledge
  – Core competencies
    • surveillance and epidemiology
    • antibiotic stewardship
    • regulatory and accreditation compliance
    • development, implementation and evaluation of an IP Program

Check the weekly MTC HIIN Upcoming Events for details and registration
Virtual Events:

• **Mar 15** – FHA HIIN | Patient & Family Engagement (PFE) Learning Collaborative Webinar: Managing and Improving Patient & Family Advisory Council (PFAC) Team Dynamics

• **Mar 20** – HRET HIIN | Culture of Safety: Safe Patient Handling

In-Person Events:

• **Mar. 22-23** – FHA HIIN | Infection Prevention Boot Camp for Novice Infection Preventionists (Orlando, FL)

• **Apr. 17** – FHA HIIN | WAKE UP to Protect Patients from Oversedation | Hospital On-set Sepsis (Jacksonville, FL)

• **Apr. 19** – FHA HIIN | WAKE UP to Protect Patients from Oversedation | Hospital On-set Sepsis (Weston, FL)

Check the weekly *MTC HIIN Upcoming Events* for details and registration.
Eligibility for Nursing CEU requires submission of an evaluation survey for each participant requesting continuing education: https://www.surveymonkey.com/r/ChasingZero031418

- Share this link with all of your participants if viewing today’s webinar as a group (Survey closes March 24)
- Be sure to include your contact information and Florida nursing license number
- FHA will report 1.0 credit hour to CE Broker and a certificate will be sent via e-mail (Please allow at least 2 weeks after the survey closes)
Cheryl D. Love, RN, BSN, BS-HCA, MBA, LHRM, CPHRM
Florida Hospital Association
cheryll@fha.org | 407-841-6230

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