• Welcome & FHA Mission to Care HIIN Update
  – Cheryl Love, RN, BSN, BS-HCA, MBA, LHRM, CPHRM, Director of Quality and Patient Safety and Improvement Advisor, FHA

• Infection Prevention Series: Decreasing Surgical Site Infections In Hysterectomy Patients
  – Linda R. Greene, RN, MPS, CIC, FAPIC, Manager of Infection Prevention, UR Highland Hospital, Rochester, NY

• Q&A

• Upcoming HIIN Events and Opportunities

• Evaluation Survey & Continuing Nursing Education
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)
- Hospital-onset MRSA Bacteremia
- Injuries from Falls and Immobility
- Pressure Ulcers (PrU)
- Sepsis
- Surgical Site Infections (SSI) – Abdominal Hysterectomy
- Venous Thromboembolisms (VTE)
- Ventilator-Associated Events (VAE/IVAC/PVAP)
- Readmissions (12% reduction)
- Worker Safety
Resources, Trainings and Tools

- SSI Change Package
- SSI Top 10 Checklist
- SOAP UP Resources
- Watch Past Webinars
- HRET HIIN Resource Library
- SSI Podcast Series
- Case Review Templates, Guidelines and more...

Hospital-Acquired Infections (HAIs)

Surgical Site Infection (SSI)

Surgical site infections are infections that occur in the wound created by an invasive surgical procedure.

The HIIN is focused on reducing SSI from:

- Colon surgery
- Abdominal hysterectomies
- Knee replacement
- Hip replacement

Goal: By September 27, 2018, a 20 percent reduction in SSI

Resources to prevent SSI:

- SSI Change Package
- SSI Checklist
- Watch Past Virtual Trainings
- HRET HIIN Resource Library
- Success Stories
- SOAP UP
Designed to reduce multiple forms of harm with simple, easy-to-accomplish activities that cut across several topics to decrease harm.

Focused on four components:

- **SOAP UP**: Hardwire Hand Hygiene
- **GET UP**: Mobilize Patients
- **WAKE UP**: Prevent Over-sedation
- **SCRIPT UP**: Optimize Inpatient Medications
FHA Mission to Care Update: SSI-Abdominal Hysterectomy

Source: HRET Comprehensive Data System, September 26, 2019

<table>
<thead>
<tr>
<th></th>
<th>Florida HIIN</th>
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<tr>
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Source: HRET Comprehensive Data System, September 26, 2019
# Infection Prevention Virtual Series

<table>
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<tr>
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<th>Topic</th>
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<td>NHSN: SSI Surveillance Identification and Analysis</td>
<td>Event archive*</td>
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<td>Nov. 20, 2018</td>
<td>SSI-Colon: How to Assess Root Cause and Prevention Strategies</td>
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<td>Dec. 18, 2018</td>
<td>NHSN: VAE Surveillance Identification and Analysis</td>
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<td>Jan. 22, 2019</td>
<td>VAE: How to Assess Root Cause and Prevention Strategies</td>
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<td>Feb. 19, 2019</td>
<td>NHSN: MRSA Bacteremia Surveillance Identification and Analysis</td>
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<td>Mar. 26, 2019</td>
<td>MRSA Bacteremia: How to Assess Root Cause and Prevention Strategies</td>
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<tr>
<td>Jul. 24, 2019</td>
<td>Implementation of Best Practices for VAE Prevention</td>
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*Access Event Archives ([Recordings](#) | [Slides](#)) on the Mission to Care HIIN Website*
## Infection Prevention Virtual Series (Continued)

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<thead>
<tr>
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<th>Topic</th>
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<tbody>
<tr>
<td>Aug. 27, 2019</td>
<td>Implementation of Strategies for the Prevention of IVAC/PVAP</td>
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<td>Sep. 27, 2019</td>
<td>SSI: Abdominal Hysterectomy</td>
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<td>Oct. 29, 2019</td>
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<td>Nov. 21, 2019</td>
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<td>Dec. 18, 2019</td>
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*Access Event Archives ([Recordings | Slides](#)) on the Mission to Care HIIN Website*
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<td>SIP Webinar Series #1: Pre-operative Strategies for Prevention of SSI</td>
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<tr>
<td>May 22, 2019</td>
<td>SIP Webinar Series #2: Intra-operative Strategies for Prevention of SSI</td>
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<tr>
<td>Jun. 25, 2019</td>
<td>SIP Webinar Series #3: Post-operative Strategies for Prevention of SSI</td>
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**Preventing Post-Surgical Harm Resource Guide** (Jun. 5, 2019)
Decreasing Surgical Site Infections In Hysterectomy Patients

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

- Discuss recent literature related to risk factors in Hysterectomy Infections
- Describe strategies to reduce risk
- Identify Components of an SSI bundle for hysterectomy patients
Polling Question #1

What is your background?

1. Infection Prevention
2. OR Nurse
3. Quality or Safety
4. SSI Champion
5. Nurse Manager
6. Other
Bacteria get into wounds
Pathogenesis of Infection

- Risk of infection increases with the number and virulence of contaminating bacteria
- Antibiotics in the tissue provide a pharmacologic means of defense to augment natural host immunity
- Bacterial resistance may play a role in gynecologic infections
  - They enable organisms to evade antibiotics
Pathogenesis

- Common pathogens arise from endogenous flora of the skin and/or vagina
  - Anaerobes
  - Staphylococcus
  - Streptococcus
Risk factors

- Patients should be assessed for risk factors as part of preparation for surgery
  - Modifiable
  - Non modifiable

- Predictors of gynecologic infections
  - Those that estimate the intrinsic degree of microbial contamination of the surgical site
  - Type and duration of surgery
  - Those that serve as markers for host susceptibility
    - Diabetes, smoking, immunosuppression
Modifiable Risk Factors

Pre-operatively

- Weight loss
- Nutritional status
- Diabetes
- Tobacco use
- Prolonged steroid use
- Remote infections
Modifiable Risk Factors

Intra-operatively

- Surgical sepsis
- Vaginal preparation
- Shaving
- Pre-op antibiotics
- Excellent surgical techniques
Modifiable Risk Factors

Post operatively

- Early ambulation
- Removal of urinary catheter
## Patient Risk Factors for Gynecologic Infections

<table>
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<tr>
<th>Risk Factor</th>
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<tbody>
<tr>
<td>Perioperative serum glucose 180-200mg/dl</td>
</tr>
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<tr>
<td>American society of anesthesiologist physical status classification system</td>
</tr>
<tr>
<td>Immunodeficiency (Chronic steroid use, chemotherapy)</td>
</tr>
<tr>
<td>MRSA status</td>
</tr>
</tbody>
</table>
Surgical site infection after hysterectomy

AeuMuro Gashaw Lake, MD; Alexandra M. McPencow, MD; Madeline A. Dick-Biascoechea, MD; Deanna K. Martin, MPH; Elisabeth A. Erekson, MD, MPH

OBJECTIVE: Our objective was to estimate the occurrence of surgical site infections (SSI) after hysterectomy and the associated risk factors.

STUDY DESIGN: We conducted a cross-sectional analysis of the 2005-2009 American College of Surgeons National Surgical Quality Improvement Program participant use data files to analyze hysterectomies. Different routes of hysterectomy were compared. The primary outcome was to identify the occurrence of 30-day superficial SSI (cellulitis) after hysterectomy. Secondary outcomes were the occurrence of deep and organ-space SSI after hysterectomy. Logistic regression models were conducted to further explore the associations of risks factors with SSI after hysterectomy.

RESULTS: A total of 13,822 women were included in our final analysis. The occurrence of postoperative cellulitis after hysterectomy was 1.6% (n = 221 women). Risk factors that were associated with cellulitis were route of hysterectomy with an adjusted odds ratio (AOR) of 3.74 (95% confidence interval [CI], 2.26–6.22) for laparotomy compared with the vaginal approach, operative time >75th percentile (AOR, 1.84; 95% CI, 1.40–2.44), American Society of Anesthesiology class ≥ 3 (AOR, 1.79; 95% CI, 1.31–2.43), body mass index ≥40 kg/m² (AOR, 2.65; 95% CI, 1.85–3.80), and diabetes mellitus (AOR, 1.54; 95% CI, 1.06–2.24). The occurrence of deep and organ-space SSI was 1.1% (n = 154 women) after hysterectomy.

CONCLUSION: Our finding of the decreased occurrence of superficial SSI after the vaginal approach for hysterectomy reaffirms the role for vaginal hysterectomy as the route of choice for hysterectomy.

Key words: hysterectomy, outcome, postoperative complication, surgical site infection

<table>
<thead>
<tr>
<th>Variable</th>
<th>Surgical site infection</th>
<th></th>
<th></th>
<th>P value</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Deep/organ-space (n = 154)</td>
<td>No deep/organ-space (n = 13,668)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Age, n (%)</td>
<td></td>
<td></td>
<td></td>
<td>1.0</td>
</tr>
<tr>
<td>&lt;80 y</td>
<td>152 (98.7)</td>
<td>13,444 (98.4)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>≥80 y</td>
<td>2 (1.3)</td>
<td>224 (1.6)</td>
<td></td>
<td></td>
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<tr>
<td>Race: white, n (%)</td>
<td>73 (47.4)</td>
<td>8321 (60.9)</td>
<td></td>
<td>.001</td>
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<tr>
<td>Ethnicity: Hispanic, n (%)</td>
<td>32 (20.8)</td>
<td>2175 (15.9)</td>
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<td>.12</td>
</tr>
<tr>
<td>Diabetes mellitus, n (%)</td>
<td>23 (14.9)</td>
<td>1000 (7.3)</td>
<td></td>
<td>&lt;.01</td>
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<tr>
<td>History of cerebrovascular accident with neurologic deficit, n (%)</td>
<td>4 (2.6)</td>
<td>62 (0.5)</td>
<td></td>
<td>&lt;.01</td>
</tr>
<tr>
<td>Current smoker, n (%)</td>
<td>47 (30.5)</td>
<td>2675 (19.6)</td>
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<td>.001</td>
</tr>
<tr>
<td>Body mass index, n (%)</td>
<td></td>
<td></td>
<td></td>
<td>&lt;.001</td>
</tr>
<tr>
<td>&lt;30 kg/m²</td>
<td>68 (44.2)</td>
<td>7608 (55.7)</td>
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<tr>
<td>≥30 and &lt;40 kg/m²</td>
<td>50 (32.5)</td>
<td>4588 (33.6)</td>
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<tr>
<td>≥40 kg/m²</td>
<td>36 (23.4)</td>
<td>1472 (10.8)</td>
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<tr>
<td>Ascites, n (%)</td>
<td>4 (2.6)</td>
<td>106 (0.8)</td>
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<td>.04</td>
</tr>
<tr>
<td>Unintentional weight loss, n (%)</td>
<td>2 (1.3)</td>
<td>64 (0.5)</td>
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<td>.17</td>
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<tr>
<td>Functional status: dependent for activities of daily living, n (%)</td>
<td>2 (1.3)</td>
<td>97 (0.7)</td>
<td></td>
<td>.30</td>
</tr>
<tr>
<td>Hysterectomy for gynecologic cancer, n (%)</td>
<td>13 (8.4)</td>
<td>8090 (6.5)</td>
<td></td>
<td>.32</td>
</tr>
<tr>
<td>Preoperative anemia: hematocrit (&lt;36%), n (%)</td>
<td>50 (33.8)</td>
<td>2974 (22.7)</td>
<td></td>
<td>&lt;.01</td>
</tr>
<tr>
<td>Preoperative creatinine &gt;1.5 mg/dL, n (%)</td>
<td>3 (2.8)</td>
<td>75 (0.9)</td>
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<td>.08</td>
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<tr>
<td>American Society of Anesthesiologists class ≥3, n (%)</td>
<td>54 (35.1)</td>
<td>2560 (18.7)</td>
<td></td>
<td>&lt;.001</td>
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<tr>
<td>Intraoperative blood transfusion, n (%)</td>
<td>8 (5.2)</td>
<td>336 (2.5)</td>
<td></td>
<td>.06</td>
</tr>
<tr>
<td>Work relative value unit²</td>
<td>17.8 ± 4.6</td>
<td>17.3 ± 3.8</td>
<td></td>
<td>.13</td>
</tr>
<tr>
<td>Operative time: &gt;75th percentile duration, n (%)</td>
<td>51 (33.1)</td>
<td>3420 (25.0)</td>
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<td>.03</td>
</tr>
<tr>
<td>Type of anesthesia: general, n (%)</td>
<td>148 (96.1)</td>
<td>13,184 (96.5)</td>
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<td>Wound class, n (%)</td>
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<td>.16</td>
</tr>
<tr>
<td>1-Clean</td>
<td>0</td>
<td>33 (0.2)</td>
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</tr>
<tr>
<td>2-Clean/contaminated</td>
<td>150 (97.4)</td>
<td>13,508 (98.8)</td>
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<td></td>
</tr>
<tr>
<td>3-Contaminated</td>
<td>3 (2.0)</td>
<td>94 (0.7)</td>
<td></td>
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</tr>
<tr>
<td>4-Dirty</td>
<td>1 (0.7)</td>
<td>33 (0.2)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Loss of ≥10% of body weight in the previous 6 months not because of exercise or dieting; ° Data are given as mean ± SD.

Knowledge of the baseline occurrence of postoperative SSI after different routes of hysterectomy and associated risk factors is important to improve patient safety after hysterectomy by helping to identify modifiable factors to prevent SSI.
Study Objective: To estimate the rate and predictors of surgical site infection (SSI) after hysterectomy performed for benign indications and to identify any association between SSI and other postoperative complications.

Design: Retrospective cohort study (Canadian Task Force classification II-2).

Setting: National Surgical Quality Improvement Program data.

Patients: Women who underwent abdominal or laparoscopic hysterectomy performed for benign indications from 2005 to 2011.

Interventions: Univariable and multivariable logistic regression analyses were used to identify predictors of SSI and its association with other postoperative complications. Odds ratios were adjusted for patient demographic data, comorbidities, preoperative laboratory values, and operative factors.
Findings

- Of 28,366 patients, 758 (3%) were diagnosed with SSI.

- SSI occurred more often after abdominal than laparoscopic hysterectomy (4% vs 2%; p < .001).

- Among patients who underwent abdominal hysterectomy, predictors of SSI included diabetes, smoking, respiratory comorbidities, overweight or obesity, American Society of Anesthesiologists class 3, perioperative blood transfusion, and operative time >180 minutes.

- Among those who underwent laparoscopic hysterectomy, predictors of SSI included perioperative blood transfusion, operative time >180 minutes, serum creatinine concentration >2 mg/dL, and platelet count > 350 000 cells/mL.
Deep and Organ Space infections

For patients with deep or organ/space SSI, significant predictors included perioperative blood transfusion and American Society of Anesthesiologists class 3 or > for abdominal hysterectomy, renal comorbidities, preoperative or perioperative blood transfusion, and operative time over 180 minutes for laparoscopic hysterectomy.

Conclusions:

- SSI occurred more often after abdominal hysterectomy than laparoscopic hysterectomy performed to treat benign gynecologic disease.
- SSI was associated with increased postoperative complications but not mortality
NYSQUIP data base 2006-2011

7630 laparoscopic and robotic hysterectomies

Multivariable regression analysis increased odds of overall complications

399 patient complications: UTI, SSI, Transfusion, PE

These associations remained statistically significant after multivariable regression analysis. Based on continuous regression modeling, each additional hour of operative time would be expected to increase odds of overall complications (odds ratio [OR], 1.4; 95% confidence interval [CI], 1.28–1.54; p < .001
## Patient Risk Factors for Gynecologic Infections

<table>
<thead>
<tr>
<th>Risk Factor</th>
<th>Description</th>
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<tr>
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<td>Immunodeficiency (Chronic steroid use, chemotherapy)</td>
<td></td>
</tr>
<tr>
<td>MRSA status</td>
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</tr>
</tbody>
</table>
Risk Factors for SSI

Alterable Risks

- Age
- Obesity
- Malnutrition
- Prolonged pre-operative stay
- Infection at distal sites
- Cancer
- Hyperglycemia
- Immunosuppression
- ASA class
- Comorbidities

Host Factors

Surgical/Environmental Factors

Microbial Factors

- Nasal/skin carriage
- Virulence
- Adherence
- Inoculum

- Abdominal site
- Wound classification
- Duration of surgery
- Urgency of surgery
- Procedure
- Hair removal
- Intraoperative contamination
- Prophylactic antibiotics
- Surgical technique
- Surgical volume
- Prior procedures
- Poor hemostasis
- Drains/foreign bodies
- Hypothermia
- Oxygenation
Actionable Items to Prevent Infections Post Surgery Complications
Preoperative Measures

- Treat remote infections
  - Manage UTI, URI and skin infection before an elective surgery
    - Treat all infections appropriately in elective surgery

- Clipping hair pre-operatively is preferred
  - Avoid shaving

- Encourage weight loss and improve nutrition
  - In planned surgery, recommend weight loss

- Immunodeficiency should be corrected if possible
  - Collaboration with other specialist(s) in patients on prolonged steroids
  - Improve immune status
Important Issues

- Control diabetes*
- Implement glycemic control of <200mg/dl
- Tobacco use
  - Discontinue use at least 30 days prior to surgery

Berrios-Torres et al. JAMA Surg 2017
Olsen MA et al. Infect Control Hosp Epidemiol 2009
Skin/Vaginal Preparation

- 2017 CDC guideline recommend preoperative bath or shower
  - Preoperative surgical site preparation
  - Chlorhexidine-alcohol is an appropriate choice unless when contraindicated
  - Chlorhexidine appears to achieve greater skin microflora reduction
  - Has greater residual activity after application than povidone-iodine
  - Alcohol could irritate vaginal mucosa

Clinical Guideline CG74. London UK
Guidelines for perioperative practice Denver (CO) AORN 2018
Intraoperative Measures

- Surgeons should maintain appropriate aseptic technique
- Minimize operative room traffic
- Minimize risk of wound disruption
- Maintain hemostasis, while preserving blood supply
- Prevent hypothermia
- Gentle tissue handle
  - Avoid inadvertent entries into hollow viscus
  - Remove devitalized tissues
- Use appropriate surgical drains and surgical materials
  - Avoid wound seroma

Boyce JM et al. MMWR Recomm Rep 2002
Mangram AJ et al. 1999
Anderson DJ et al. Infect Control Hosp Epidemiol 2014
Is pre-op screening for BV beneficial?

Preoperative screening for bacterial vaginosis maybe considered as a possible means to decrease surgical site infections (SSI)

Soper DE et al. AJOG 1990
Larsson PG et al. Obstet Gynecol 1991
Workowski KA et al. MMWR Recomm Rep 2015
Rationale

- For most SSIs, the source of pathogens is the endogenous flora of the patient's skin.
- Unique challenge in GYN - potential pathogenic microorganisms may come from the skin or ascend from the vagina and endocervix to the operative sites (gram-negative bacilli, enterococci, group B streptococci, and anaerobes).
ACOG guidance on prevention of surgical-site infection in gynecologic surgery

Surgical site infections

Surgical site infection (SSI) after gynecological surgery is a significant cause of postoperative morbidity leading to repeated hospital visits. These infections also incur heavy social and economic burden on patients and the healthcare system.
Preoperative prophylaxis:

- Treat any remote infections before any elective gynecological procedure.

- Screen women for diabetes before the procedure and if found hyperglycemic, aim at blood glucose <200 mg/dL with or without diabetes.

- Patients should have a full body shower or bath with Chlorhexidine instead of soap.

- Screen for bacterial vaginosis pre-operatively, if found positive initiate treatment with metronidazole or another CDC recommended regimen

- Vaginal cleaning before surgery is done by 4% chlorhexidine gluconate or povidone-iodine (only povidone–iodine is FDA approved for vaginal preparation)
Polling Question #2

What is your standard prep?

1. Povidone iodine
2. CHG
3. CHG/ Alcohol
Background: The use of chlorhexidine gluconate (CHG) as an intraoperative vaginal preparation has been shown to be more effective than vaginal povidone-iodine (PI) in decreasing vaginal bacterial colony counts. PI remains the standard vaginal preparation because of concerns of CHG’s potential for vaginal irritation. The primary outcome of this study is a comparison of the rate of patient-reported vaginal irritation between 2% CHG and PI.

Methods: Consecutive patients were enrolled in a pre-post study. Group 1 consisted of consecutive patients who received PI as a vaginal preparation. Group 2 consisted of consecutive patients who received 2% CHG as a vaginal preparation. Patients used a standardized instrument to report irritation to trained nurse practitioners 1 day after surgery.

Results: A total of 117 patients received vaginal operative preparation during the course of the study, with 64 patients in group 1 and 53 patients in group 2. Of the patients in group 1, 60 (93.7%) reported no vaginal irritation, 3 (4.69%) reported mild irritation, and 1 (1.56%) reported moderate irritation. In group 2 (2% CHG vaginal preparation), all of the patients (100%) reported no vaginal irritation ($P = .38$).

Conclusions: The use of 2% CHG as a vaginal operative preparation is not associated with increased vaginal irritation compared with PI in gynecologic surgery. It can safely be used, taking advantage of its efficacy in reducing vaginal bacterial colony counts.
What about bundles?

Gynecology: Clinical Practice and Quality

Decreased Surgical Site Infection Rate in Hysterectomy
Effect of a Gynecology-Specific Bundle

Sarah E. Andiman, MD, Xiao Xu, PhD, John M. Boyce, MD, Elizabeth M. Ludwig, BA, Heidi R. W. Rillstone, RN, Vrunda B. Desai, MD, and Linda L. Fan, MD
Background

Quality Improvement Project
Developed comprehensive bundle
2,009 hysterectomies performed
61 SSIs
Sustained reduction in last 8 months ( [OR] 0.46, P= .01)
Components

1. Chlorhexidine gluconate (implemented at the start of the study period): Chlorhexidine gluconate-impregnated wipes were dispensed at the preoperative visit or in the preoperative unit before surgery and patients were counseled regarding their use.

2. Patient-controlled preoperative warming (implemented at the start of the study period): While awaiting surgery, patients were provided with forced-air warming devices to promote normothermia.

3. Abdominal prep with CHG/Alcohol, single vaginal preparation (4% chlorhexidine–4% isopropyl alcohol solution) were made standard across all obstetric and gynecologic services (purposeful CHG). Mandatory education with video
Components

4. Sterile dressing (implemented at the start of the study period):

Postoperatively, sterile dressings were maintained for a minimum of 24 hours and were removed by 48 hours postoperatively.

Use of topical skin adhesives was left up to the individual surgeon and was not considered part of the primary sterile dressing.

Patients who were discharged before 24 hours postoperatively were instructed to remove their dressings at home, between 24 and 48 hours after surgery.
Other Measures

5. Active warming (forced air)

6. Antibiotic standardization (added metronidazole for high risk patients or bowel involvement)

7. Timely and Constructive Feedback
Polling Question #3

What is your protocol for warming?

1. Active warming for all patients
2. Warming dependent on the patient
3. Passive warming – blankets, warm IV fluids
Consensus Bundle on Prevention of Surgical Site Infections After Major Gynecologic Surgery

Joseph E. Pellegrini, PhD, CRNA, Paloma Toledo, MD, MPH, David E. Soper, MD, William C. Bradford, DO, Deborah A. Cruz, MSN, RNC, Barbara S. Levy, MD, and Lauren A. Lemieux, BS

Surgical site infections are the most common complication of surgery in the United States. Of surgeries in women of reproductive age, hysterectomy is one of the most frequently performed, second only to cesarean birth. Therefore, prevention of surgical site infections in women undergoing gynecologic surgery is an ideal topic for a patient safety bundle. The primary purpose of this safety bundle is to provide recommendations that can be implemented into any surgical environment in an effort to reduce the incidence of surgical site infection. This bundle was developed by a multidisciplinary team convened by the Council on Patient Safety in Women’s Health Care. The bundle is organized into four domains: Readiness, Recognition and Prevention, Response, and Reporting and Systems Learning. In addition to recommendations for practice, each of the domains stresses communication and teamwork between all members of the surgical team. Although the bundle components are designed to be adaptable to work in a variety of clinical settings, standardization within institutions is encouraged. (Anesth Analg 2017;124:233–42)
Consensus Bundle

Council on Patient Safety in Women’s Health Care, a collaborative entity convened by the American College of Obstetricians and Gynecologists

Organized bundle into 4 domains:

1. Readiness
2. Recognition and Prevention
3. Response,
4. Reporting and Systems Learning
Readiness (Every Facility)

1. Establish standard preoperative care instructions and education for women undergoing major gynecologic surgery (such as hysterectomy), including postoperative wound care instructions (written and verbal)

2. Establish a system that delineates responsibility for every member of the surgical team

3. Establish standards for temperature regulation with regard to:
   - Ambient operating room temperature
   - Patient normothermia

4. Standardize the selection and timing of administration of prophylactic antibiotics, ideally using order sets or checklists

5. Standardize the timing of discontinuation of prophylactic antibiotics, ideally using order sets or checklists

6. Establish standard on appropriate skin preparation, both preoperatively and postoperatively
Recognition and Prevention (Every Patient)

7. Assess patient risk preoperatively for surgical site infection using the following criteria:
   • Blood glucose level
   • Body mass index
   • Immunodeficiency
   • Methicillin-resistant *Staphylococcus aureus* status
   • Nutritional status
   • Smoking status
**Response (Every Case)**
8. Develop intraoperative “Timeouts” to address antibiotic dosage, timing, prophylaxis issues, and patient-specific issues
9. Reassess patient risk for surgical site infection based on length of surgery, potential bowel incision, vaginal contamination, and amount of blood loss
10. Provide postoperative care instructions and education to women undergoing major gynecologic surgery (such as hysterectomy) and family members or other support persons

**Reporting and Systems Learning (Every Facility)**
11. Establish a culture of huddles for high-risk patients
12. Create system to analyze and report surgical site infection data
13. Monitor outcomes and process metrics
14. Actively collect and share physician-specific surgical site infection data with all surgeons as part of their ongoing professional practice evaluation
15. Standardize a process to actively monitor and collect surgical site infection data with postdischarge follow-up
Changed Bundle to include:

- 4% CHG application
- MRSA screening
- Added Metronidazole
- Glove change with separate sterile instruments for closure

Organ space SSI reduction Post Implementation (P < .043)
Polling Question #4

Do you have a physician review of SSIs in hysterectomy patients?

1. No
2. Yes-general surgeon or quality MD
3. Epidemiologist
4. GYN MD
5. GYN MD plus other above
Processes of Care

Our Aim is ZERO
More Upcoming Virtual Events

• **October 1, 2019 @ 2:00 p.m. -3:00 p.m. ET**  
  Sepsis Alliance | Sepsis Coordinator Network - Informatics Basics

• **October 2, 2019 @ 12:00 - 1:00 p.m.**  
  FHA | Monthly Quality Hot Topics #11

• **November 6, 2019 @ 12:00 - 1:00 p.m.**  
  FHA | Monthly Quality Hot Topics #12

• **December 4, 2019 @ 12:00 - 1:00 p.m.**  
  FHA | Monthly Quality Hot Topics #13

Check the weekly [MTC HIIN Upcoming Events](#) for details and registration
Upcoming HIIN Regional Forums

**Focus on Implementation and Improvement...**

**In-Person Meetings**

**HIGHLIGHTS:**

- Support and resources for targeted harm topics
- Inter-facility discussion highlighting approaches and solutions that have been successful in moving the needle toward ZERO HARM
- Peer-learning forum for discussing successes and challenges, along with implementation and sustainability practices

**Suggested Audience:**
All HIIN project leads and clinical leaders are encouraged to attend, specifically key team members who are engaged in direct patient care and can bring evidence-based practice to the bedside.

**Dates / Locations / Topics:**

- **Sep. 24 - North FL | Sepsis, VAE**
  Baptist Medical Center South, Jacksonville
- **Sep. 30 - Southeast FL | Falls, Sepsis, SSI**
  Memorial Regional Hospital, Hollywood
- **Oct. 3 - Central FL | Falls, Sepsis**
  FHA Corporate Office, Orlando
- **Oct. 10 - Panhandle | Falls, HAPI, Sepsis**
  Sacred Heart Hospital, Pensacola
- **Nov. 6 - Southwest FL | Falls, Sepsis**
  Gulf Coast Medical Center, Ft. Myers

**Register to attend one or more:** [http://www.cvent.com/d/5yqv9](http://www.cvent.com/d/5yqv9)
FLORIDA HOSPITAL ASSOCIATION

ANNUAL MEETING

OCTOBER 23-25
HYATT REGENCY GRAND CYPRESS
ORLANDO

OPENING KEYNOTE
William H. McRaven, USN (Ret.),
University of Texas System
Chancellor and Retired U.S. Navy
Four-Star Admiral

CLOSING KEYNOTE
Doris Kearns Goodwin,
Presidential Historian and
Pulitzer Prize-Winning Author

Register today:
www.FHAAnnualMeeting.com
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