

FHCA 2014 Annual Conference & Trade Show

CE Session #48 – Inspiring the CULTURE of How and When We CULTURE

Thursday, July 10 – 4:00 to 6:00 p.m.

Canary 4 – Clinical/Care Practice

Upon completion of this presentation, the learner will be able to:

- discuss key lessons learned through retrospective and prospective data analysis and comprehensive review of facility systems regarding UTI management;
- review strategies to reframe the culture of culturing unnecessarily; and
- review selected protocols to facilitate accurate assessment and symptom identification and appropriate specimen collection techniques.

Seminar Description:

The CDC reports that 30-50 percent of long term care residents have a positive urine culture without any symptoms of a urinary tract infection (UTI). Many residents are inappropriately placed on antibiotics and overuse can lead to antibiotic resistant infections and related morbidity and mortality. Staff in 11 Florida facilities are working with the state health department to reframe the resident care environment to promote critical thinking, nursing assessment and awareness of key protocols that can influence a decrease in antibiotic use for asymptomatic bacteriuria and urinary tract infections which do not meet the 2012 McGeer criteria. This session will discuss the data findings and strategies recommended.

Presenter Bio(s):

Deborah Afasano, BSN, RNC, RAC-CT, HCRM, is Vice President of Clinical Services for Avante Group, Inc. Debbie is a certified director of nursing, end-of-life trainer through ELNEC and a licensed health care risk manager. Her diverse nursing background spans 30 plus years in acute and long term care settings. Debbie is the immediate past chair of the FHCA Quality Foundation Senior Clinicians' Council.

A.C. Burke, MA is the health care-associated infection prevention program manager for the Florida Department of Health. She has been working in the health care field for over 15 years and has experience in both the private and public sectors. In her role with FDOH, she and her staff have established a multi-disciplinary advisory board, developed partnerships across the continuum of care and produced collaboratives for the prevention of health care-associated infections in both acute and long term care facilities.

Marty Casper is Vice President of Operations for Avante Group, Inc. where he is responsible for the operations of their 20 skilled nursing facilities and 4 assisted living facilities in Florida, North Carolina and Virginia. He has over 40 years of progressively responsible experience in administration of health care facilities, including analysis and evaluation of systems and procedures followed by implementation of innovative programs for the betterment of patient care and service. He is a certified nursing home administrator and earned his Master's Degree in Public Health and Hospital Administration from Yale University.

Wendy Davis, RN-BC, RAC-CT is currently the Regional Director of Clinical Services – FL for the Avante Group. She has a diverse background in nursing spanning 20+ years with an extensive history in LTC nursing management. Her current responsibilities entail regional oversight of the clinical management of 11 Skilled Nursing and 2 Assisted Living facilities in the state of Florida. Wendy's focus has remained on the collaborative team development of quality focused clinical systems and strengthening quality care delivery to the bedside through on site leadership, nurse mentoring and training.

CHANGING THE CULTURE OF WHEN TO CULTURE

Avante Nursing Home Pilot Project
Florida Health Care Association Conference
July 10, 2014
Debbie Afasano, BSN, RNC, CDONA, HCRM
A.C. Burke, MA,
Martin Casper, MPH, CNHA
Wendy Davis, RN, BC, RAC-CT

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Presentation Objectives

- ▣ To identify an opportunity for antimicrobial stewardship in long-term care (LTC).
- ▣ To understand the difference between urinary tract infection (UTI) and asymptomatic bacteriuria (ASB).
- ▣ To identify the signs and symptoms of a urinary tract infection.
- ▣ To review pilot project results.

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Pilot Project Goals

- ▣ To reduce inappropriate antibiotic treatment among residents with no documented evidence of a UTI.
 - Antibiotic use is considered inappropriate if documentation for urine culture (i.e. symptoms) and culture results do not meet McGeer 2012 criteria for UTI.
- ▣ To create a resident care environment that fosters resident care staff thinking critically to ensure appropriate assessment of residents for signs and symptoms of urinary tract infections.

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Pilot Project Objectives

- ▣ By March 2014, decrease by 30% the proportion of urine cultures from residents with no documented symptoms of urinary tract infections.
- ▣ By March 2014, decrease by 30% the proportion of residents receiving antibiotic treatment when there is no documented evidence of a UTI.

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Timeline

- ▣ Retrospective baseline measurement period
 - January-March 2013
- ▣ Prospective data collection
 - July 2013-March 2014
- ▣ Outcome measurement period
 - January-March 2014
- ▣ Training
 - July 2013

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WHY?

Why focus on antibiotic stewardship for asymptomatic bacteriuria and urinary tract infections?

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Antibiotic Use in LTC, Where Are We?



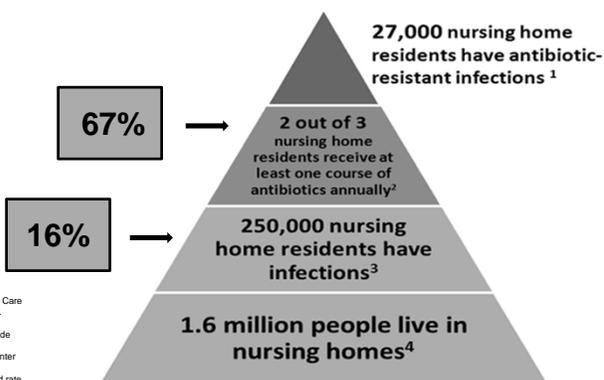
¹ Centers for Medicare and Medicaid Services, Long Term Care Minimum Data Set, Resident profile table as of 05/02/2055, Baltimore, MD.
² Loeb, M et al. Antibiotic use in Ontario facilities that provide chronic care. J Gen Intern Med 2001; 16: 376-383.
³ Centers for Disease Control and Prevention, National Center for Health statistics, 1999 National Nursing Home Survey. Nursing Home Residents, number, percent distribution, and rate per 10,000, by age at interview, according to sex, race, and region: United States, 1999.
⁴ Centers for Disease Control and Prevention, National Center for Health statistics, 1999 National Nursing Home Survey. Nursing Home Residents, number, percent distribution, and rate per 10,000, by age at interview, according to sex, race, and region: United States, 1999.

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Does This Add Up?



¹ Centers for Medicare and Medicaid Services, Long Term Care Minimum Data Set, Resident profile table as of 05/02/2055, Baltimore, MD.
² Loeb, M et al. Antibiotic use in Ontario facilities that provide chronic care. J Gen Intern Med 2001; 16: 376-383.
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⁴ Centers for Disease Control and Prevention, National Center for Health statistics, 1999 National Nursing Home Survey. Nursing Home Residents, number, percent distribution, and rate per 10,000, by age at interview, according to sex, race, and region: United States, 1999.

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Antibiotic Use In LTC

- ▣ UTI is one of the most common infections treated with antibiotics each year in nursing homes.

- ▣ Estimates of the cost of antibiotics in the long-term care setting range from \$38 million to \$137 million per year.

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Why High Antibiotic Use in LTC?

- ▣ Inconsistent use of criteria for diagnosing infection and/or initiating antibiotics

- ▣ Challenges with separating **colonization** from true **infection**
 - Colonization does not require treatment!

- ▣ Antibiotics for prophylaxis

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Why Should We Be Concerned?

- ▣ Negative outcomes
 - Increased risk of hospitalization and death
 - Increased risk of *Clostridium difficile* infection
 - Treatment costs
- ▣ Selection of antibiotic-resistant organisms
- ▣ Fewer antibiotics coming into the marketplace
- ▣ Shared resource

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Prevent *C. difficile* Infections?

A study conducted on residents in the U.S. Department of Veterans Affairs long-term care facilities found that residents with ASB who were treated with antibiotics are 8.5 times more likely to develop a *C. difficile* infection within the three months following the course of antibiotics.

Phillips, C. BMC Geriatrics, 2012, 12:73

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In the Literature

Adverse Outcomes in Nursing Home Residents With Increased Episodes of Observed Bacteriuria

Rituparna Das, MD; Virginia Towle, MPhil; Peter H. Van Ness PhD, MPH; Manisha Juthani-Mehta, MD

- The article examined ASB and adverse outcomes for residents with catheters.
- No association was found with hospitalization for UTI or change in mental status.
- Adverse outcomes were associated with antibiotic use.

Infect Control Hosp Epidemiol 2011; 32(1):84-86

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In the Literature

Asymptomatic Bacteriuria, Antibiotic Use, and Suspected UTI in Four Nursing Homes

Phillips, CD et. al. *BMC Geriatrics* 2012; 12:73

- Study confirmed findings for frequent use of antibiotics for ASB in nursing homes.
- Half of prescriptions for antibiotics for UTI occurred without documented signs or symptoms of UTI.

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UTI in LTC

- ▣ The most common bacterial infection in LTC.
- ▣ UTI is also the most common cause of bacteremia.
- ▣ **Studies have consistently shown that about 30%-50% of frail, elderly long-term care residents can have a positive urine culture even without any symptoms of a urinary tract infection (bacteriuria).**
- ▣ Asymptomatic bacteriuria is more common than UTI.

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What Is Asymptomatic Bacteriuria?

- ▣ Presence of bacteria in the urine which may result in a positive urine culture, in the absence of new signs and symptoms of urinary tract infection
- ▣ Prevalence
 - Up to 50% of females in LTC have ASB
 - Most common patient group to have ASB is elderly, diabetic women
 - 14-40% of males in LTC have ASB

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The Difference

ASYMPTOMATIC BACTERIURIA

- ☐ NO SYMPTOMS
 - Documented bacteria in the urine
 - **Do not treat with antibiotics**
- ☐ Exception: pregnancy and urological procedures



URINARY TRACT INFECTION

- ☐ SYMPTOMS
 - Documented bacteria in the urine
 - **Treat with antibiotics**



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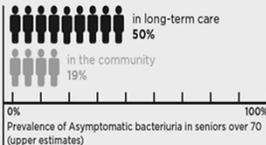
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Mass. Infection Prevention Partnership
Prepared for Massachusetts long term care facilities

Treating Asymptomatic Bacteriuria: All harm, No Benefit

High Prevalence of Asymptomatic Bacteriuria

- › The bladder is normally colonized in many elderly people
- › A positive urinalysis or culture in the absence of symptoms reveals **colonization, not infection**
- › Treatment of asymptomatic bacteriuria is **not recommended**



It's Hard to Ignore A Positive Test

Habitual Testing + Prevalent Colonization = Unnecessary prescriptions & missing the real diagnosis



Unnecessary Rx and Missed Diagnoses Harm Patients

- › Drug-drug interactions
- › Renal & other complications
- › Increase of multi-drug resistant bacteria
- › *C. difficile* infection
- › Nausea and vomiting
- › Drug allergies
- › Missing the real diagnosis



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To Treat or Not to Treat?

- ▣ Because many residents have chronic bacteriuria, the research-based literature suggests treating only symptomatic UTIs.
- ▣ Both Society for Healthcare Epidemiology of America (SHEA) and Infectious Disease Society of America (IDSA) reflect this statement in their recommendations.

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National Guidelines

- ▣ Treatment

Infectious Diseases Society of America Guidelines
for the Diagnosis and Treatment of Asymptomatic
Bacteriuria in Adults

Lindsay E. Nicolle,¹ Suzanne Bradley,² Richard Colgan,³ James C. Rice,⁴ Anthony Schaeffer,⁵ and Thomas M. Hooton⁶

¹University of Manitoba, Winnipeg, Canada; ²University of Michigan, Ann Arbor; ³University of Maryland, Baltimore; ⁴University of Texas, Galveston; ⁵Northwestern University, Chicago, Illinois; and ⁶University of Washington, Seattle

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National Guidelines

- ▣ Surveillance Criteria for LTC
 - Stone, Nimalie, MD et. al., ***Surveillance Definitions of Infections in Long-Term Care Facilities: Revisiting the McGeer Criteria***, Infection Control and Hospital Epidemiology, Vol. 33, No. 10 (October 2012), pp. 965-977
 - National Healthcare Safety Network (NHSN) LTC Module
 - Do not replace clinical decision making

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McGeer Criteria: UTI Without Catheter

At least 1 sign or symptom described below +
microbiologic criteria (i.e. positive urine analysis)

Symptoms

- ▣ Acute dysuria or acute pain, swelling, or tenderness of the testes, epididymis, or prostate

OR...

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McGeer Criteria: UTI Without Catheter

- ▣ Fever or leukocytosis and at least 1 of the following localizing urinary tract subcriteria:
 - Acute costovertebral angle pain or tenderness
 - Suprapubic pain
 - Gross hematuria
 - New or marked increase in incontinence
 - New or marked increase in urgency
 - New or marked increase in frequency
- In the absence of fever or leukocytosis, then 2 or more of the following localizing urinary tract subcriteria:
 - Suprapubic pain
 - Gross hematuria
 - New or marked increase in incontinence
 - New or marked increase in urgency
 - New or marked increase in frequency

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McGeer Criteria: UTI Without Catheter

Symptom(s) + microbiologic criteria (i.e. positive urine culture)

Microbiologic Criteria

- At least 100,000 (10^5) cfu/mL of no more than 2 species of microorganisms in a clean catch (e.g. voided) urine sample
- At least 100 (10^2) cfu/mL of any number of organisms in a specimen collected by in-and-out catheter

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McGeer Criteria: UTI With Indwelling Catheter

At least one sign or symptom described below:

- ▣ Fever, rigors, or new-onset hypotension, with no alternate site of infection
- ▣ Either acute change in mental status or acute functional decline, with no alternate diagnosis and leukocytosis
- ▣ New-onset suprapubic pain or costovertebral angle pain or tenderness
- ▣ Purulent discharge from around the catheter or acute pain, swelling, or tenderness of the testes, epididymis, or prostate

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McGeer Criteria: UTI Without Indwelling Catheter

At least 1 sign or symptom previously described + microbiologic criteria (i.e. positive urine culture)

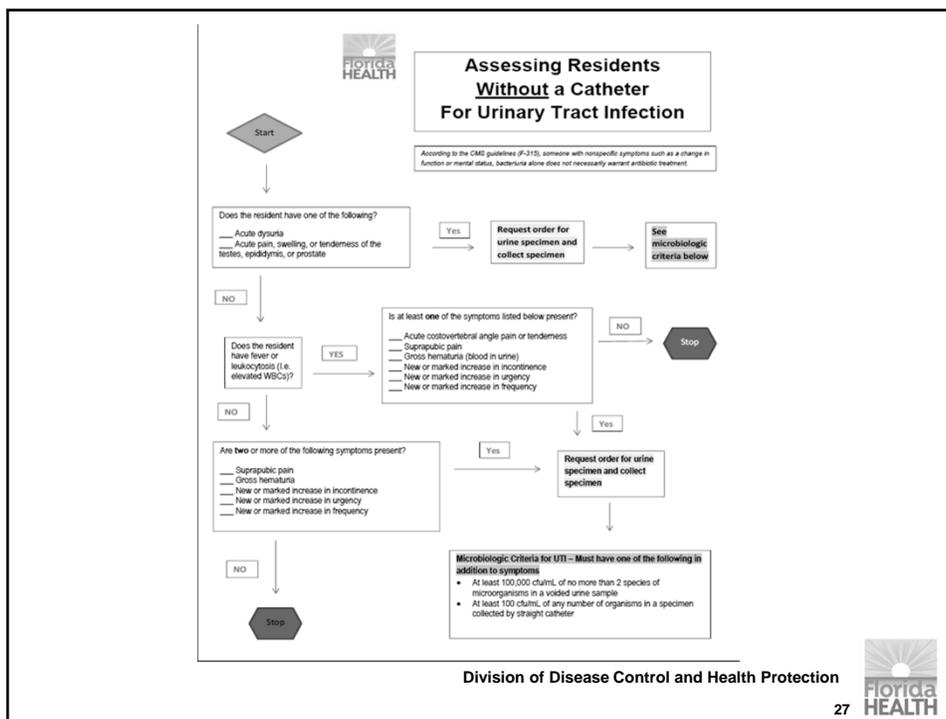
Microbiologic Criteria

- ▣ At least 100,000 (10^5) cfu/mL of any number of organisms

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National Guidelines

- ❑ Not on the list of symptoms
 - Urine odor or color
 - Falls
- ❑ Caution for mental status
 - UTI less likely without specific symptoms
 - Non-specific symptoms may be due to a variety of causes: pain, depression, constipation, dehydration, poor sleep, or medication side effects
 - Must consider range of possible causes
 - UTI should be at the bottom of the list

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Low-Hanging Fruit

- ▣ Decrease antibiotic use for ASB
 - Properly identify UTI and ASB using national criteria.
 - Implement appropriate pericare and hydration protocols.
 - Properly collect and handle urine specimens.
 - Limit screening and treatment with antimicrobials only to residents with symptomatic UTI.

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Data Collection

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What will we report to DOH?

- ▣ Establish the critical data necessary to facilitate goal evaluation and develop approved reporting tool within the scope of HIPPA compliance.
- ▣ CHALLENGE - Meaningful data needed shifted and evolved in the 1st quarter.
- ▣ SOLUTION - Ongoing revisions to the reporting template.
- ▣ SOLUTION - Consistent use of medical record numbers for HIPPA compliance. Identifier for internal purposes/corrections and planned data validation activities.

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Reporting Tool Changes

- ▣ Added antibiotic start and stop dates-
November 2013
 - Try to identify potential empiric antibiotic use=less than 3 days
- ▣ Added comments column
 - Identify alternate reasons for urine culture
- ▣ Ongoing data challenge: identifying antibiotic use for other infections (i.e. not UTI) and how accounted for in data collection and ensuring consistency in reporting

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Reporting Tool

PROSPECTIVE DATA COLLECTION

Please populate the fields below for each urine specimen laboratory result from July 2013 to April 2014. All data should be entered into this form electronically and submitted to the FDOH monthly. Enter a unique identifier and report date (only) and then select responses from the drop-down menus in each cell.

Please refer to 2012 McGee criteria for determination of appropriate symptoms based on the presence/absence of an indwelling catheter.

Please submit this spreadsheet when completed to Wendy Davis a wadavis@avantagroup.com.

ID	Facility Name:	Report Date	Ordering Provider	Date Specimen Collected	Collection Method	Colony-forming Units	Organisms	Report Monthly/Year:	STAT Lab	Antibiotics	Symptoms	Abx Start Date	Abx Stop Date	Comments
	1													
2														
3														
4														
5														
6														
7														
8														
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What data sources are available?

- ❑ Available reports and from which sources – Lab, Pharmacy, Medical Records
- ❑ Establish collaboration for project data management from external sources
- ❑ CHALLENGE – Data needed was fragmented across multiple available sources = increased work burden on facility staff
- ❑ SOLUTION – Worked extensively with our lab provider and developed a dedicated report that contains as many needed reporting elements as possible = ONE STOP SHOPPING

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Facility Level Process

- ▣ Who will be responsible? How much time is it estimated to take on a monthly basis?
- ▣ CHALLENGE – Maintaining consistent clinical oversight and organized reporting compliance
 - 2-4 hour monthly time burden after learning curve needs were met
- ▣ CHALLENGE – Nursing leadership turnover
- ▣ SOLUTIONS –
 - Monthly follow-up and interaction with regional support via calls and e-mails
 - Integration of pilot study tasks into DON onboarding

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Managing the Information Flow

- ▣ Establish time line for facility receipt of devoted lab report.
- ▣ Establish time line for DOH receipt of approved reporting tool.
- ▣ Establish feedback mechanisms based on aggregate facility data information via webinars.
- ▣ CHALLENGE – Receipt of DOH reporting tool on time
- ▣ SOLUTION – Monthly assistance as needed

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Next Steps

- ▣ Data Quality/Data Validation
 - How do we “measure up”?
 - Can the results be validated.....

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Pilot Project Results

Results reflect data from 100% (11/11)
nursing homes.

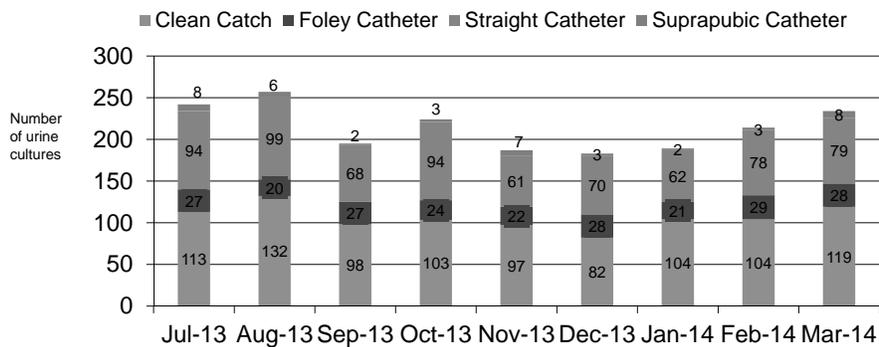
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Number of Cultures

Figure 1: Total Number of Urine Cultures by Collection Method, July 2013-March 2014



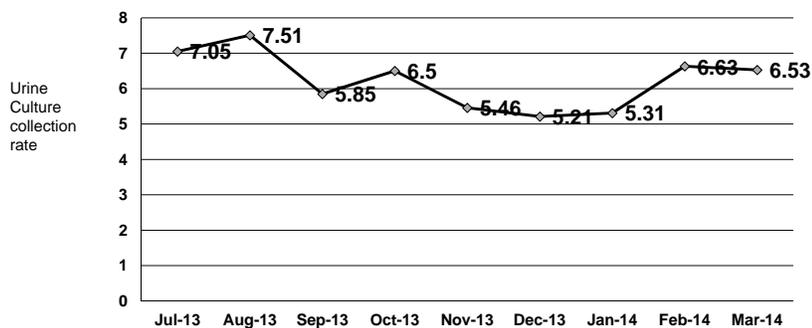
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Culture Rate

Figure 2: Urine Cultures Collected Per 1000 Resident Days, July 2013-March 2014



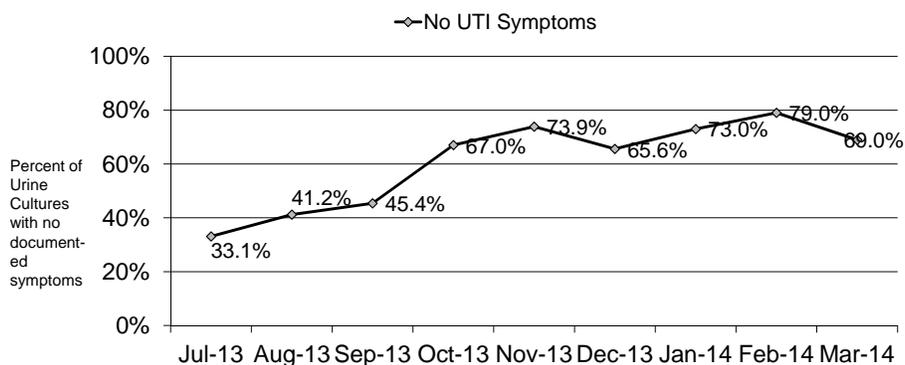
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Urine Cultures and No Symptoms

Figure 3: Proportion of Urine Cultures From Residents With No Documented UTI Symptoms*, July 2013-March, 2014



*Based on 2012 McGeer Criteria

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Urine Cultures and No Symptoms

- ▣ July 2013-September 2013
 - Range: 0% (0/65)-84% (68/81)
 - Mean: 40% (275/695)
 - Facilities above the mean: 55% (6/11)
- ▣ January 2014-March 2014
 - Range: xx
 - Mean: xx
 - Facilities above the mean: xx

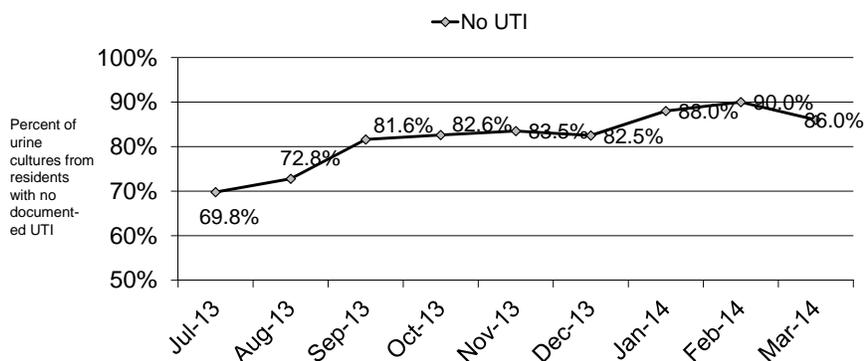
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UTI Criteria Not Met

Figure 4: Proportion of Urine Cultures From Residents With No Documented UTI*, July 2013-March 2014



*Based on 2012 McGeer Criteria

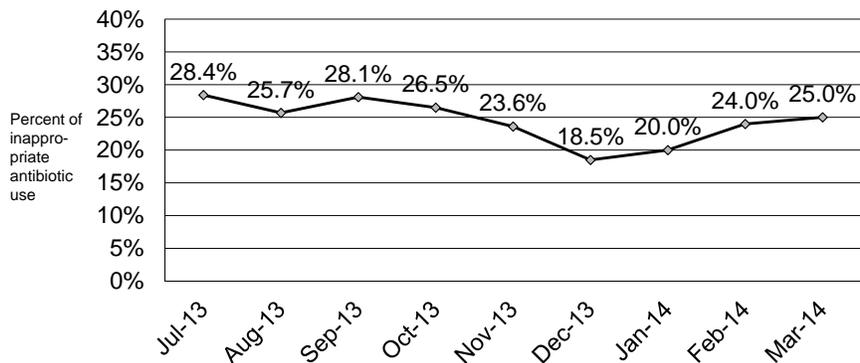
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Antibiotic Use

Figure 5: Proportion of Urine Cultures With No UTI* and Received Antibiotic Therapy, July 2013– March 2014



*Based on 2012 McGeer Criteria

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Inappropriate Antibiotic Use

Dates	Range	Mean	% Facilities > Mean
Jan–March 2013*	4% (2/45)- 85% (11/13)	26% (111/435)	45% (5/11)
July–Sept 2013	0% (0/51)- 47% (23/49)	27%(141/516)	73% (8/11)
Oct–Dec 2013	9% (3/32)- 45% (15/33)	24%(114/480)	55% (6/11)
Jan-March 2014	5% (2/39)- 39%(18/46)	24% (132/561)	45% (5/11)

*The baseline period, January-March 2013, was retrospective data collection and only used laboratory results to determine inappropriate antibiotic use. All other date ranges include lab data and symptom data.

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Empiric Use

- ▣ Potential empiric use=less than 3 days
- ▣ November: 5 occurrences
- ▣ December: 1 occurrence
- ▣ January: 1 occurrence
- ▣ February: 2 occurrences
- ▣ March: 4 occurrences

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Current Status

Parameter	Baseline Q1 2013 (Jan-Mar)	2013 Q3 (July-Sep)	2013 Q4 (Oct-Dec)	2014 Q1 (Jan-Mar)
# Urine cultures	833	695	595	XX/XX
Urine cultures per 1000 resident days	8.83	6.81	5.72	xxx
% No UTI symptoms	Not applicable	40% (275/695)	69% (409/595)	XXX
% No UTI	52% (435/833) *Lab results only*	74% (516/695)	83% (493/595)	XXX
% Urine contamination	39% (322/833)	36% (248/695)	47% (278/595)	XXX
Antibiotics with no UTI (symptoms and/or positive labs)	26% (111/435) *Lab results only*	27% (141/516)	23% (114/493)	XXX

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Data Validation

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Process

- ▣ Line list for urine cultures and antibiotic use
- ▣ Random, stratified sample
 - Symptoms
 - Collection method/catheter status
- ▣ Approximately 15 medical records per facility
 - Range: 11-16
- ▣ Culture results from July 2013-December 2013

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Results

- ▣ Correct line list
 - X% correct entries
 - Most common error: correctly identifying symptoms
 - All except 1 facility had \geq 80% of lab results correctly listed
- ▣ Inappropriate antibiotic use
 - X% inappropriate antibiotic use
 - Range: 33%-60%

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Benefits and Opportunities

Changing Direction To Effect Change



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The Reality Checks of the Pilot

- ❖ We have made some positive clinical changes but we are far from done...
- ❖ Our data supports the need to continue to drive change and support a culture that **advocates for antibiotic stewardship.**
- ❖ Our data indicates the need to better manage specimen collection to **reduce contamination.**
- ❖ **Today** we are closer to the bedside and able to influence outcomes through heightened awareness of current culturing norms in LTC



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Clinical System Integration



Is this necessary?

- ❖ **Integration** into the DON onboarding process.
- ❖ **Integration** into the a.m. clinical meeting process.
- ❖ **Integration** and targeted communication.
- ❖ **Integration** with a letter and focused discussion with Medical directors.
- ❖ **Integration** into clinical report card reviews.
- ❖ **Integration** into current monthly QA.
- ❖ **Integration** into documentation systems. Piloting of various assessment templates.
- ❖ **Integration** by piloting internal audits.

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Changing our Culture Through Lessons Learned



- ❖ **Data Mining** revealed underlying issues:
 - **STAT labs** - Created STAT revelations!
 - Contaminated specimens “cost” time and money
 - Repeat tests were not always ordered : Were they really needed?
- ❖ **Who** at the facility level could champion and impact bedside efficacy?
- ❖ **Where** were the time points for progress or back slides?
- ❖ **Why** the gaps? Was our sample size too large?

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Obtaining Good Root Cause Through Contaminated Data



- ❖ An immediate revelation in the 1st quarter was the incidence of **STAT urines**.
 - Outsourced STAT labs = increased cost!
 - WHY STAT?
- ❖ **Contaminated specimens** is often not included in IC discussions.
- ❖ **No clinical criteria is applicable to contaminated specimens**.
 - Discovery and awareness was a **BIG success** of the pilot.

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Contaminated Data *continued*

- ❖ **What is the cause and effect?**
 - ❖ Did the resident receive antibiotics and feel better?
 - ❖ Or did the staff encourage fluids; increase toileting efforts; provide other comfort measures that calmed the clinical presentation on a case by case basis?
- ❖ **What really happened?**

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Information to Consider

- ❖ **What does a contaminated urine cost?**
- ✓ Estimated lab processing cost = \$12.00 per specimen.
- ✓ Licensed nurse time - assessment; physician contact; order processing time; specimen collection/oversight; follow-up = cost.
- ✓ Resident care: What is really required?
- ✓ **ADD MOST CURRENT CONTAMINATION RATE X COST X 11 FACILITIES = POTENTIAL SAVINGS.**



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Answers Fit Into A QAPI Culture... Not An Unnecessary Culture!

- ❖ Eliminate myths: DONs persist in accepting and attempt outdated changes.
 - For example, all urines obtained via straight cath.
- ❖ It is time to stop and understand HOW and WHY this occurs.
- ❖ We must ensure physicians stay informed of the results and the outcomes.

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Process Change

We have looked closer at the process:

- ❖ Training for the “right” staff
- ❖ Oversight to the people most closely involved.
(e.g. select 11-7 staff who normally collect urine)
- ❖ Criteria to address how to handle follow up regarding contaminated specimens

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Our Response? Manage the Outcomes



- ❖ **Extend** the study for an additional 90 days.
- ❖ **Reduce** the sample size to 3 facilities for implementation of further targeted action.
- ❖ **Develop**, write and implement a specific Quality Plan for the targeted sample.
- ❖ **Increase** the feedback via webinar display of aggregate results to the facilities.
- ❖ **Require** the facilities to present updated data to medical directors and process through internal QA.
- ❖ Apply QAPI Thinking through systematic analysis and oversight.

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CREATING A CULTURE

That Knows, Why, When, and How To Culture

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What Did We Do? What Did We Learn? Where Do We Go?



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Governance and Leadership

- ▣ Who will be good team members? Who might be a champion and co champion?
- ▣ Who would be a Collection Specialist?
- ▣ What resources might you need?
- ▣ Are there any special supply or equipment needs?
- ▣ Are residents aware of the plan?

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PIP Action Planning= A Culture Of Accountability

PIP Action Planning Worksheet

FOCUS represents: Find the opportunity, Organize and Prioritize the Data, Collect additional information, Understand the root cause, Select a Process for Improvement

PIP TEAM _____ Date: _____
 Team Leader _____ Timekeeper _____
 Recorder _____ Facilitator _____

1. What is the problem? What are you trying to accomplish? (Team Purpose/Opportunity Statement)

2. Identify team members: Strive for diversity to get varied opinions and insight.

Identify Chair _____ Co Chair _____
 Identify Additional Team members:

Establish set time, place, agenda

How will you know that a change is an improvement?

Data Sources: _____

Who is responsible for collecting? When will it be collected? _____

Define simple measures that can be compared before and after you have implemented your action steps to gauge success, goal dates, and who is responsible to gather the data

1. _____
2. _____
3. _____

Other Resources/Education: How will they be utilized and shared?

1. _____
2. _____
3. _____

Identify any equipment needs or requests:

What
Is the
problem?

What is the
goal?

Who are
the
resources?

What is
required?



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PIP Action Planning Worksheet

3. What changes can you make that will result in an improvement?
What action step(s) can your team take to remove a barrier or improve despite the existence of a barrier?

ACTION STEP	PERSON(S) RESPONSIBLE	COMPLETION DATE	OUTCOME
1.			
2.			
3.			
4.			
5.			

How will information be shared? When will that occur?

What will you use for ongoing feedback and monitoring?

Current update:

Submitted to QAPI/QA&A on: _____

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Have the
Right Team

Commit to
the Change

Opportunity Statement

- ▣ *An opportunity exists to reduce the rate of contaminated urine specimens (following review and analysis of ASB pilot data collected) and to utilize our knowledge to further influence change and establish more effective ways to obtain specimens*
- ▣ *An opportunity exists to reduce the rate of antibiotic use to treat residents for UTI (when clinical criteria items standardized per the McGreer criteria are not met) and to use our knowledge to mobilize expertise, sustain critical thinking, and continue to move outcomes in a positive direction*

Change the Culture of Cultures

- ▣ What are you aiming for?
- ▣ Where are the other types of resources you will use to solve the problem, educate, or better manage the process?
- ▣ Communication systems to support?

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Education Is On Going

PERI CARE RETURN DEMONSTRATION

1. Knocked on door. Screened resident. Pulled window curtain if necessary.
2. Addressed resident, introduced self and explained what was being done.
3. Gathered equipment
4. Washed hands and put on gloves (universal precautions).
5. Removed soiled incontinence product and disposed of properly (put in trash bag, tied shut).
6. Did not put soiled incontinence product or linen on floor.
7. Told resident before using wipes/washcloth/perineal wash, "Wipe may feel cold."
8. Used clean section for each wipe/washcloth or used a new wipe/washcloth each time.
9. Used correct technique for peri-care on female vs. male residents.
Female: Spread labia, wipe one side, then the other, and then the middle, wiping toward the rectal area and never wiping back and forth. Directed to clean the rectal and buttocks area.
 Male: Pull foreskin back if resident is uncircumcised. Clean the tip of the penis using a circular motion starting at the urethra and working outward. Clean shaft of the penis with firm downward strokes. Clean the scrotum.
10. Used no other products unless resident has order.
11. Removed gloves before touching clothing, bed rail, cubicle curtain, etc.
12. Washed hands before leaving room.
13. Correctly disposed of incontinence product in soiled utility room or if in isolation in red barrel in room.
14. Used proper body mechanics and proper positioning for resident during entire procedure.
15. Maintained resident dignity and privacy throughout entire procedure.

Staff Name: _____ Score: _____
 Evaluator: _____ Date: _____
 Comments: _____

SBAR

STOP AND WATCH

McGeer Criteria

Asymptomatic
Bacteruria?

Collection Methods.....Coding Symptoms

Physician Philosophy

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Feedback, Data Systems, Monitoring

- ▣ How will you obtain data?
- ▣ Types of data? Sources?
- ▣ What data will you look at? How will it be collected and interpreted?

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Collection Specialist

The image shows a screenshot of an Excel spreadsheet titled "Specimen Collection Specialist Log". The spreadsheet is displayed in a window with the following menu bar: File, Home, Insert, Page Layout, Formulas, Data, Review, View. The ribbon is set to the "Home" tab, showing various options for font, alignment, and styles. The spreadsheet itself has a grid with columns labeled A through G and rows numbered 1 through 9. The data is organized as follows:

	Date	Resident	Pre collection pericare or intervention	Barriers	Obtained	Stored appropriately post collection	Results
1							
2							
3							
4							
5							
6							
7							
8							
9							

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Systematic Analysis and Oversight

- ▣ What will you do to help root cause?
- ▣ How will you assign responsibility?
- ▣ How will you measure success?
- ▣ How will you get feedback on the outcomes?
- ▣ How will it be captured and reported?
- ▣ How will you determine next steps and maintain the gain
- ▣ How will you celebrate the success?
- ▣ How will it flow to QAPI as part of your QAA?

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Area of Focus/Concern	Action Item	Responsible Party	Target Date	Status
1. An opportunity exists to reduce the rate of contaminated urine specimens (following review and analysis of ASB pilot data collected). 2. An opportunity exists to reduce the rate of antibiotic use to treat residents for UTI when clinical criteria items standardized per the McGreer criteria are not met.	1. Three of eleven facilities have been selected to implement focused action steps in consonance with ongoing data collection (Mt. Dora, St. Cloud and Ocala).		May 1, 2014	
	2. The three facilities will establish 2 staff members from each shift who will be responsible for urine specimen collection. CNAs who are trained to obtain clean catch specimens at the direction and with the oversight of a licensed nurse are acceptable.		May 9, 2014	
	3. The designated staff members including a nurse for catheter collections, will be re-trained on urine specimen collection using facility approved training materials and competencies. (Send competencies on peri-care and catheter care; power point on catheterized and non-catheterized specimen collection criteria and specimen handling). Competencies will be observed to confirm compliance.		May 9, 2014	
	4. Residents that are able to participate in education on pericare will be included as aprt of specimen collection and preventative measures. The resident care plan will be reviewed to ensure pericare and hydration is a part of the current plan.		May 9, 2014	
	5. The designated staff members will be educated on the technique as well as how to make the resident comfortable for the specimen collection.		May 9, 2014	
	6. The designees will meet with the DON to review current facility percentage of contaminated data, potential reasons for contamination, and the importance of their role in the		May 6-7, 2014	

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	<p>study.</p> <p>7. The designated Collection Specialist will establish a realistic reduction goal with the DON for the next 30 days (50%) The designated collection teams will be informed that their performance and insight will be discussed as part of this pilot review and presentation.</p> <p>8. Designated staff will identify and record on the Specimen Collection Specialist Log any barriers to the obtaining of the specimen e.g. resident behavior and resistance, and interventions they employed to facilitate a non contaminated collection.</p> <p>9. U/A and C&S orders will be reviewed by the DON/Designee daily as part of the a.m. clinical meeting review as follows: review the clinical record for documented symptoms to establish if these fall within the McGeer criteria. The DON/Designee will then decide what if any further action steps are needed on a case by case basis. (May include further probing to establish that existing s/s were not recorded effectively; may include discussion with the physician regarding the necessity of the specimen; may include enhanced/repeated staff training; changing the time of urine specimen collection to facilitate improved oversight).</p> <p>10. U/A and C&S orders will be recorded on the white board as a mechanism of tracking until the results are received.</p> <p>11. Per facility protocol, the physician will be notified of all lab results.</p> <p>12. The ASB Pilot program and McGeer criteria will be repeated with the Medical Director at the next scheduled QA meeting. The facility specific data collected to date along with this PIP will be presented.</p>		<p>May 6-7, 2014</p> <p>TBD – start by Monday, 5/12.</p> <p>Ongoing</p> <p>Ongoing</p> <p>Ongoing</p> <p>Facility specific</p>	
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4. McGeer A et al: ***Definitions of Infection for Surveillance in Long-term Care Facilities***, Am J Infect Control 19(1):1-7, 1991.
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THANK YOU!

For being part of our presentation and
sharing our Vision for a New Culture of
Culturing!

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