



Infection Surveillance Project

Participant Newsletter

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2011 - Q1

Dates of Interest

Thursday, March 31
End of 1st Quarter, 2011

Wed-Fri: April 6-8
MAHC Annual Convention
Lake of the Ozarks, MO

Friday, May 13
2nd Quarter data due

Agencies should receive
2011 Q1 reports by May 27

Thursday, June 30
End of 2nd Quarter

Thursday, August 12
2nd Quarter data due

Agencies should receive
2011 Q2 reports by
August 26

Friday, September 30
End of 3rd Quarter

Friday, November 11
3rd Quarter data due

Agencies should receive
2011 Q3 reports by
November 25

Friday, December 30
End of 4th Quarter

Best Practices from February Participant Call

During the February ISP conference call, participants discussed data utilization (best practices) within their organization. One participant said that they have found from their data analysis that clients with catheters for long periods of time (30 days or more) have a higher risk of infection. These clients were then targeted. They looked at the reason these clients had the catheter and if they were necessary or only for convenience. For those that were more for convenience, what could

be done? For example, physical therapy could help with getting to the bathroom, urologist referrals could result in determining if bladder issues or not, etc. Also, patient education is a factor. A teaching folder is presented to the client that includes information such as recognizing signs and symptoms of a UTI, personal hygiene information, caring for a catheter information, etc. All of these have resulted in a reduced infection rate. Another organization followed the APIC recom-

mendation and only uses silver tip catheters. They have seen a reduction in their infection rate for long term foley patients. Another participant was tracking silicon cath. They found that in short term cath patients there was no difference but in long term cath patients it was helpful in the reduction of infections. Since the call, MAHC has received information related to studies on silver tipped catheters. We will be posting this information on the listserv soon.

Adverse Reactions to Latex in the Clinical Setting—A Urologic Perspective



Hypersensitivity to latex, affecting both patients and healthcare, is well documented. Since 1979, the U.S. Food and Drug Administration has received thousands of reports of type-1 hypersensitivity reactions to latex products including anaphylaxis leading to death. Chronic latex exposure via an indwelling urethral catheter is associated with adverse effects including cytotoxicity, urethritis, urethral stricture, increased risk of urinary tract infection, and encrustation with blockage

of urinary drainage. In a past issue of *Infection Control Resource*, authors provide a detailed discussion of latex-associated reactions in the patient undergoing long-term indwelling catheterization. Healthcare practitioners are often challenged by the common catheter-care issues to prevent infections. These include questions about how often to change the catheter, when to treat urinary tract infections, catheter size, and preventing encrustations and blockage.

Adding to the confusion is the choice of catheter product; currently available models include silicone, latex, silicone- and TEFLON-coated latex, hydrophilic gel, and anti-septic- and antimicrobial-impregnated catheters. The article describes how judicious use of catheters in individual situations, size of catheter, all-silicone catheters, and adequate fluid intake can go far to delay the onset of complications. Go to http://infectioncontrolresource.org/Past_Issues/IC6.pdf to download the full article.

Infection Control Program Among Seniors Reduces Deaths by 10%, Could Save 'Trillions' in Waste



An infection control program developed by the Johns Hopkins University School of Medicine has helped lower death rates in hospital intensive care units by 10%, experts say. A Thompson/Reuters analysis of the program, which could be adapted for other healthcare settings, asserts it could save \$3.6 trillion in waste over

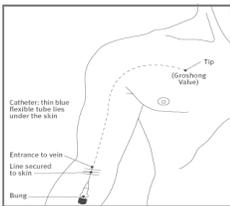
10 years if it becomes more widely used. The program emphasizes changing a provider's culture by using checklists to prevent errors and reduce costs, Reuters reports. Additional safety precautions include common sense methods such as thorough hand washing; questioning when and if a catheter is needed; put-

ting coverings on the patient and the nurse or physician when a catheter is being inserted; and seeking alternatives to central lines in the groin area. Researchers at Johns Hopkins reviewed records for 1.3 million ICU patients over the age of 65 for the study. The analysis focused on the impact of the program when it was

implemented across ICU departments in Michigan "Independent of whether they were in our program, mortality of all Medicare patients admitted to the ICU went down 10% compared to all 11 surrounding states—that is incredible," said lead researcher, Dr. Peter Pronovost.

Hospice Infection Surveillance Project

MAHC is excited to begin a Hospice Infection Surveillance project, however, a minimum of 10 companies must commit prior to the startup. If you have not yet expressed your interest to MAHC and are interested in participating, please contact Carol at carol@homecaremissouri.org for more information.



Critically ill patients in the emergency department and intensive care unit may have central venous catheters (CVCs) inserted into a neck, chest, or groin vein. These catheters are used to deliver medications and fluids, as well as monitor central venous pressure to regulate fluid balance. Resident physicians normally learn how to do the procedure by observing someone else. However, there are now simulation training programs that allow residents to practice a procedure

Simulation Training Improves Insertion of Central Venous Catheters

over and over again before actually performing it on a live patient. A new study finds that such simulation training improves CVC insertion performance, including first-time insertion. It also appears to be more effective than traditional training. For this study, 90 first and second year residents received a slide presentation and then watched three videos demonstrating the insertion technique. This was followed by hands-on simulation training using a simulator designed for this purpose. Another group of 95 residents

were trained in CVC insertion by observing at the bedside. Senior physicians served as independent raters and did not know what type of training each resident received. A total of 115 residents performed 494 CVC insertions, which were observed by the raters. The first measure was how successful a resident was at accessing the vein and inserting a needle under ultrasound guidance. The success rate for this was 51 percent in the simulation group and 37 percent in the bedside group.

The second measure of success was the actual insertion of the CVC. Success rates were 78 percent for the simulation group and 67 percent for the bedside group. According to the researchers, simulation training was independently and significantly associated with first needle and CVC insertion. This was true regardless of the resident's specialty or the patient's medical problems. The study was supported in part by the Agency for Healthcare Research and Quality.

**Don't forget to mark your calendars for
MAHC's 2011 Annual Conference & Exposition
April 6-8, 2011—Tan-Tar-A Resort**

