

How to Balance and Prioritise Infection Prevention Activities in the Era of Mandatory Reporting and Accreditation

A Quality Director's Perspective

ACIPC International Conference

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Healthscope



Agenda

- 1) External requirements
- 2) Balancing & prioritising activities
- 3) Example: HACs

Perspective: Board member, Quality Director,
Consumer



1. What are the external requirements?



External requirements

Often external requirements drive our quality program. We know that this can be:

- Accreditation
 - State health department priorities
 - Mandatory reporting
 - Public reporting
-
- But what if these priority areas don't align with your local risk issues?

Public reporting: national level

MyHospitals

- SAB
 - MSSA
 - MRSA
 - Since 2010/11 to current
- Cdif (recently removed)
- Hand hygiene
 - not updated since 2015

Private Hospitals

Healthscope

- SAB
- Cdif (recently removed)
- Hand hygiene (split by professional group)

Ramsay

- SAB
- Cdif
- Hand hygiene

Public Reporting: Victorian public hospitals

Victorian Health Services Performance

Emergency department status Statewide Health services Hospitals Area mental health services Ambulance services Resources

Search performance data

Statistical information on Victoria's public hospitals and health services.

Activity and performance data are updated quarterly, with an aim to provide greater transparency and a better understanding of Victoria's public hospitals and health and ambulance services.

Search for service by name, suburb or postcode

Find near me

- Emergency care
- Elective surgery
- Dental care
- Ambulance services
- Patients treated
- Specialist clinics
- Quality, safety and patient experience
- Mental health

Healthcare-associated infections

Intensive care unit central line associated blood stream infections per 1,000 device days

The rate of central line associated blood stream infections per central line days.

Staphylococcus aureus bacteraemias (SAB) infections per 10,000 patient days

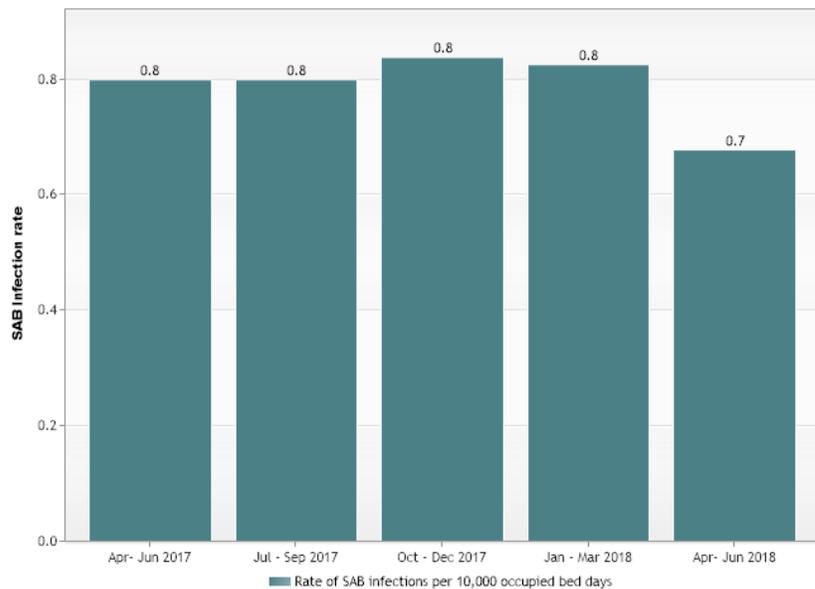
This report details the number of infections per 10,000 occupied bed days.

Surgical site infection surveillance status

The Surgical Site Infection Surveillance indicator focuses on surgical procedures and high risk invasive procedures.

Public Reporting: Victorian public hospitals

1. SAB



2. ICU Central Line BSI

Intensive care unit central-line-associated bloodstream infections per 1,000 device days Close

Category: Quality, Safety and Patient Experience » Healthcare-associated infections

	Apr - Jun 2017	Jul - Sep 2017	Oct - Dec 2017	Jan - Mar 2018	Apr - Jun 2018
Alfred Hospital, The	0.8	0.0	0.8	0.0	0.0
Austin Hospital	5.2	0.9	0.9	0.0	0.0
Ballarat Hospital	0.0	0.0	4.4	0.0	7.4
Bendigo Hospital, The	0.0	0.0	0.0	0.0	0.0
Box Hill Hospital	0.0	0.0	0.0	0.0	0.0
Central Gippsland Health Service - Sale	0.0	0.0	0.0	0.0	0.0
Dandenong Hospital	0.0	0.0	0.0	0.0	2.0
Frankston Hospital	0.0	1.3	1.3	0.0	0.0
Hamilton Base Hospital	0.0	0.0	0.0	0.0	0.0
Latrobe Regional Hospital	0.0	0.0	0.0	0.0	0.0
Maroondah Hospital	0.0	0.0	0.0	0.0	0.0
Monash Medical Centre - Clayton	0.0	1.3	0.0	0.7	0.0
Northeast Health Wangaratta Hospital	0.0	0.0	0.0	0.0	0.0
Northern Hospital, The	0.0	5.2	0.0	0.0	0.0
Peter MacCallum Cancer Centre	N/A	N/A	N/A	N/A	N/A
Royal Children's Hospital	2.2	1.5	2.4	0.0	2.3
Royal Melbourne Hospital	0.6	1.3	1.3	1.6	0.6
Shepparton Hospital	0.0	0.0	0.0	0.0	0.0
South West Healthcare - Warrnambool	0.0	0.0	7.1	0.0	0.0
St Vincent's Hospital	0.0	1.0	1.1	3.6	3.5
Sunshine Hospital	0.0	1.8	0.0	0.0	0.0
University Hospital Geelong	0.0	2.3	0.0	0.0	0.0
Western Hospital - Footscray	0.0	0.0	0.0	0.0	0.0
Wimmera Base Hospital - Horsham	0.0	0.0	0.0	0.0	0.0
Wodonga Hospital	0.0	0.0	0.0	0.0	0.0
Total	0.8	0.9	0.8	0.5	0.7

3. Surgical Site Infection Surveillance

- (CAGS, Hip & knee arthroplasty, ICU central line bacteraemia).
- Reported as: “Surgical site infection surveillance status – achieved or not achieved”
- Not very useful

Public reporting: Victorian public hospitals

Victorian Quality Account

- Consumer focused
- Requires healthcare associated infection indicators with rate, target, benchmarked data, action.
 - SAB
 - ICU central line BSI
 - Staff flu immunisation
- Open to interpretation by health services – what to include?
- Hand hygiene removed for current year

A new RMH initiative that uses a whole-of-hospital approach to sepsis diagnosis and treatment has resulted in a 49 per cent reduction in death, compared to episodes of care prior to the project starting; 67 per cent reduction in admission to the Intensive Care Unit (ICU), 50 per cent reduction in time to receive antibiotics and a 43 per cent decrease in the length of stay in hospital.

The program – known as the RMH Whole of Hospital Sepsis Pathway – has standardised

There were **0 cases** of Staphylococcus Aureus, a common cause of hospital acquired infection.



100%

Hand hygiene compliance with the Department of Health and Human Services targets.

In 2016 the Eye and Ear **exceeded the 75% target** set by the Department of Health and Human Services for staff flu vaccination rates.

↑
100%



Accreditation requirements – NSQHSS 2nd edition

Quality KPIs

NSQHSS criteria	Indicator Name and Number
3.4	Hospital-acquired SAB
3.4	SAB - MRSA
3.4	SAB - MSSA
3.8	Hand Hygiene rates
3.14	Infection Control Risk Assessments
1.28	HAC rate

Education KPIs

NSQHSS criteria	Indicator Name and Number
3.14	Sterilisation staff training

Audits

NSQHSS criteria	AUDIT
3.2, 3.4	Infection control policy compliance, effectiveness, standard & transmission based precautions
3.10	Invasive devices audit
3.9	Aseptic non-touch technique
3.16	Antimicrobial stewardship, usage and resistance
3.11	Cleaning audit
3.15, 8.4.1	Riskman infection incident & risk register review

2. Balancing & prioritising activities



Issues and obstacles

- Obstacles to an optimally designed infection prevention program include
 - Externally imposed, prescriptive standards
 - Mandatory training (especially NSQHSS 1st edition)
 - Externally imposed indicators & targets
 - Multiple jurisdictions with variable definitions and data collection methods for the same measure.
- Health services can spend inordinate amounts of time on external ideas of quality, rather than problems that are more locally relevant.
- The focus on aggregated measures of quality can result in oversimplification of infection prevention into one or two indicators reported publicly, or at Board or funder level.

Reporting vs acting

- Reporting indicators and infection prevention activities should align.
- Priorities for reporting may not always match priorities for action.
- **Report** indicators in all areas of risk & requirement
- **Take action** on problem areas

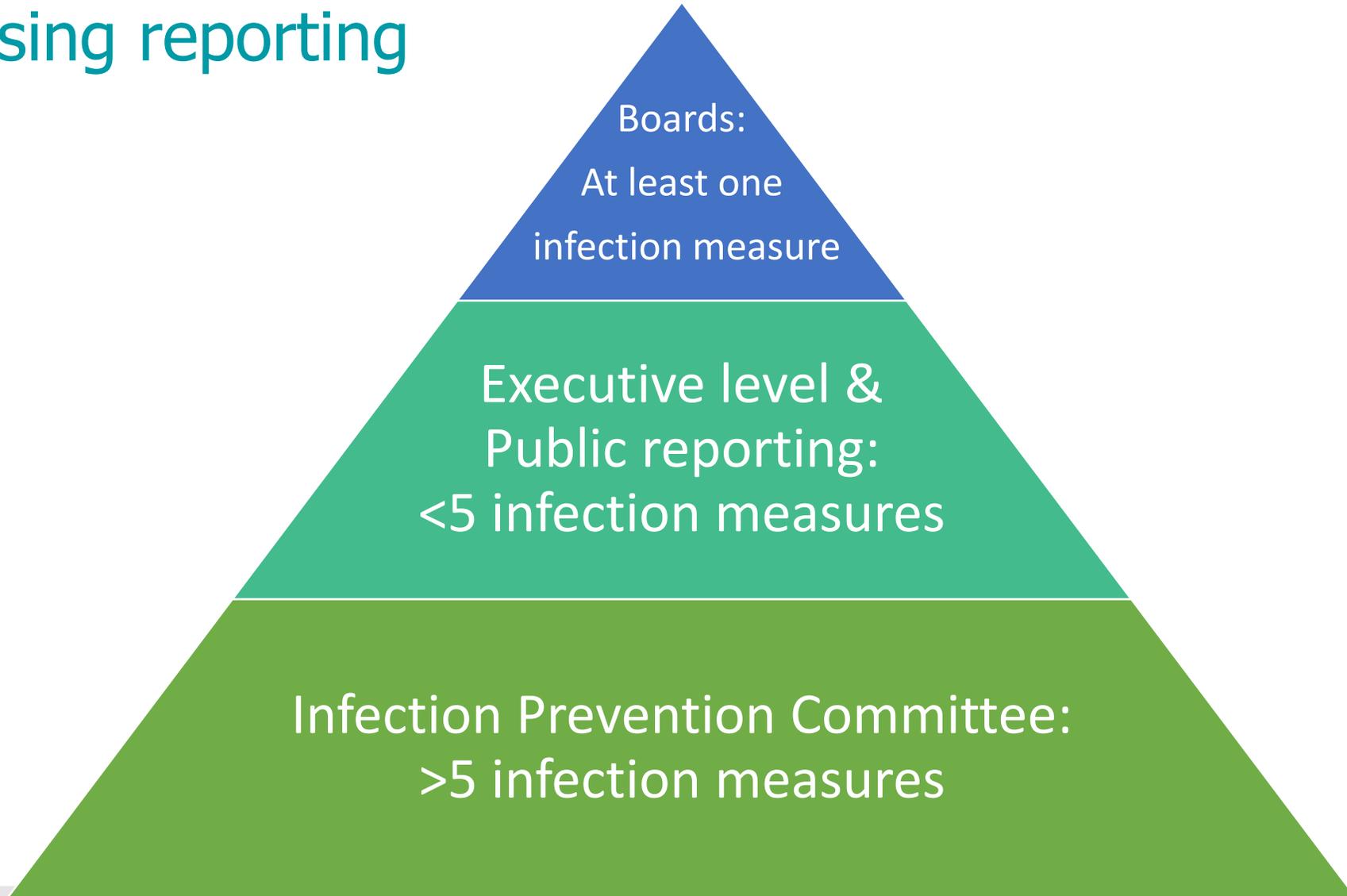
How to prioritise reporting?

When selecting reporting priorities, the following factors need to be considered:

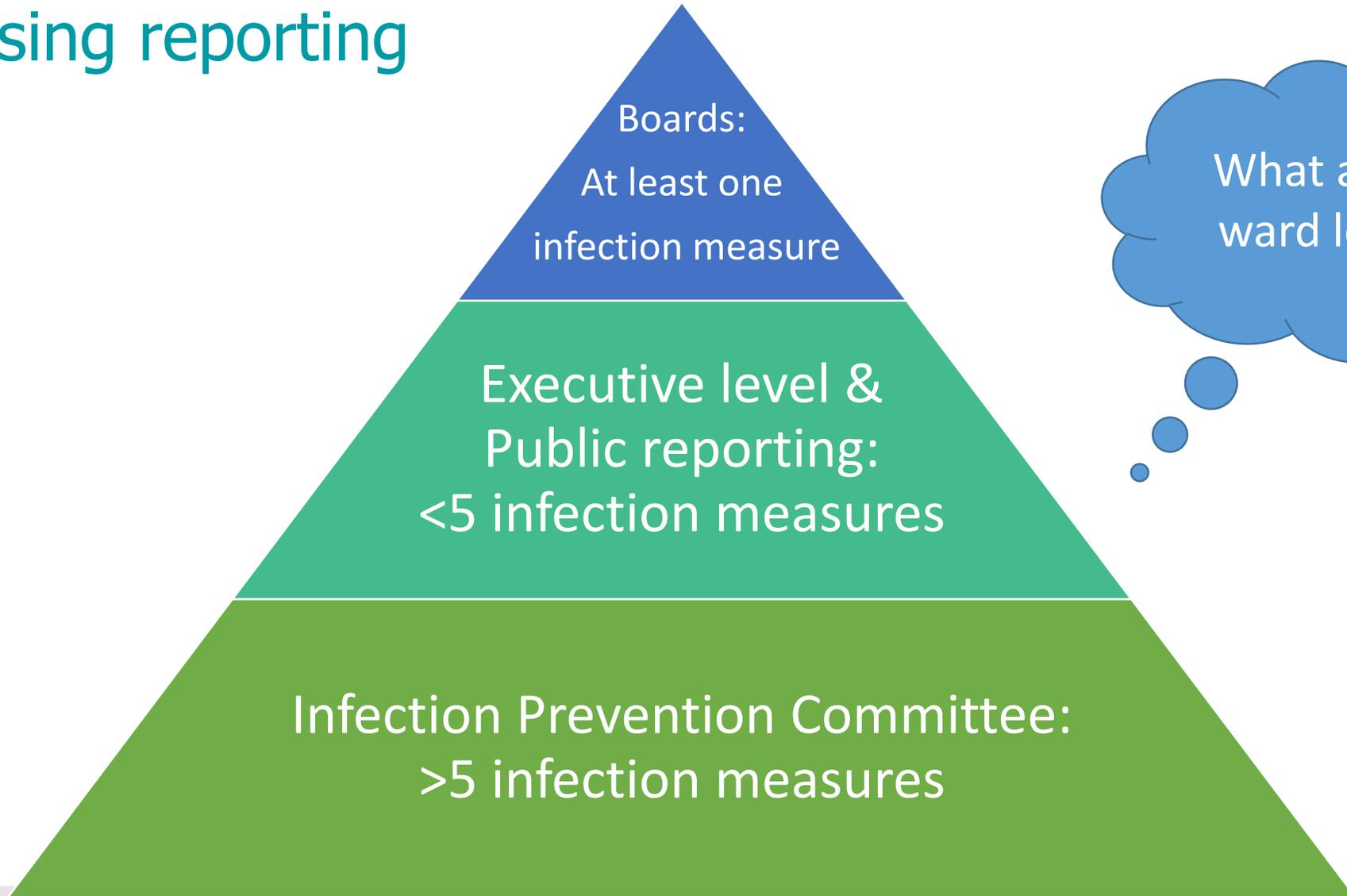
- Requirements of funders & government
- National Safety & Quality Health Service Standards (2nd edition from 2019)
- The highest risks in your healthcare setting
- Current problem areas in your healthcare setting
- Requirements of other external stakeholders
- The consumer perspective
- Board/Executive requirements and preferences
- Industry standards

Also must consider: available data collection systems.

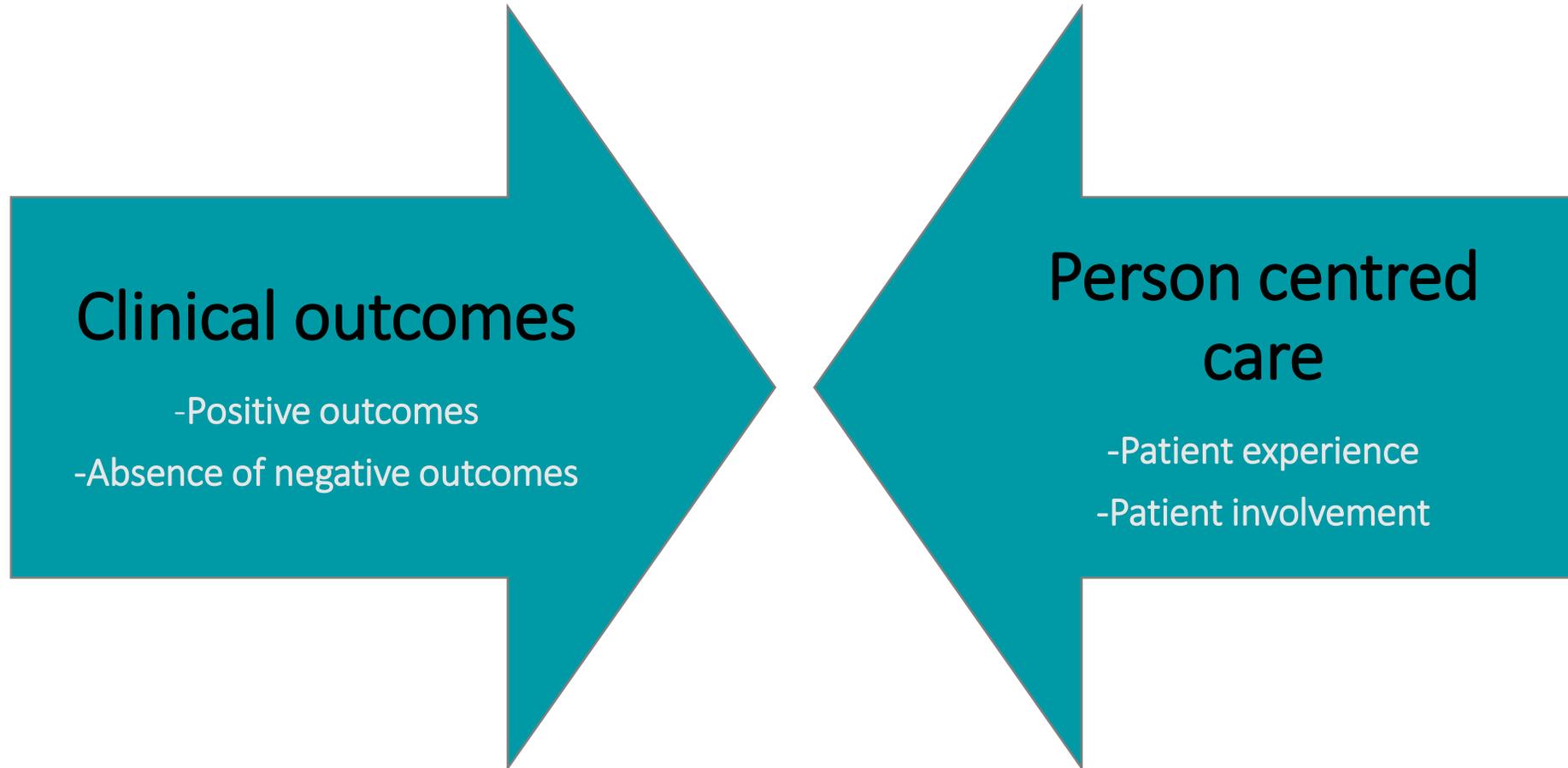
Prioritising reporting



Prioritising reporting



Other competing priorities



3. Example: Hospital Acquired Complications (HACs)



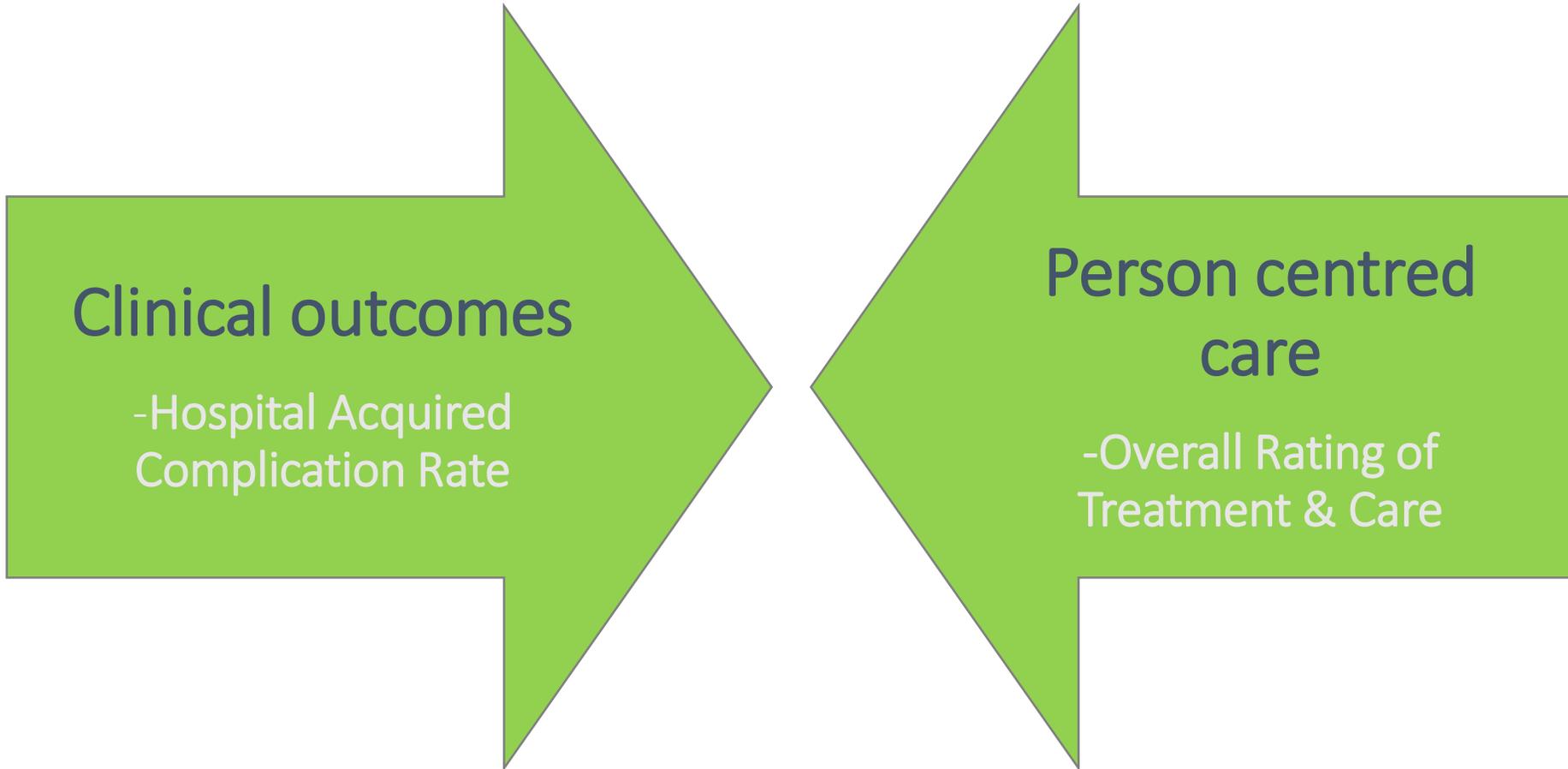
Hospital Acquired Complications (HAC)

- Mandatory government/funder indicator
- HAC is a complication for which clinical risk mitigation strategies may reduce (but not necessarily eliminate) the risk of that complication occurring.
- National list of 16 HACs developed by the Australian Commission on Safety and Quality in Health Care

1. Pressure injury
2. Falls resulting in fracture or other intracranial injury
3. **Healthcare associated infection**
4. Surgical complication requiring unplanned return to theatre
5. Unplanned intensive care unit admission
6. Respiratory complications
7. Venous thromboembolism
8. Renal failure
9. Gastrointestinal bleeding
10. Medication complications
11. Delirium
12. Persistent incontinence
13. Malnutrition
14. Cardiac complications
15. 3rd & 4th degree perineal laceration during delivery
16. Neonatal birth trauma

1. UTI
2. Surgical site infection
3. Pneumonia
4. Blood stream
5. Central & peripheral line
6. Multi resistant
7. Prosthesis associated
8. Gastro

Healthscope – 2 core KPIs



HAC issues with HAI

- Reliance on coding and clinical documentation
- Inconsistency between infections recorded via coding, incident reporting and surveillance databases.
- Difficulty determining if infection condition onset was prior to or after admission
- Risk adjustment methodology is controversial
- Use of administrative data for clinical interpretation:
 - Financial payments from coding – to reimburse what was treated
 - Just because it's treated, doesn't mean it's hospital acquired
 - Just because it's hospital acquired, doesn't mean it's preventable

Healthcare associated infection surveillance using electronic surveillance systems (ESS) is ideal:

- automated systems often still require manual review
- never match each other – coding, surveillance systems, incident reporting

HAC rate – use in practice

- Where reported & how often?
- Removing data problems is useful
 - Condition onset flag – present on admission?
 - UTIs a problem (coding tends to over-report. Only 67% real.)
 - Undiagnosed issues on admission
 - In rehab, UTIs are common but not CAUTI.
- Raw rates are useful, but just a start. Need risk adjustment.
- Coding is an established source of truth.
 - Theory that financial penalties and financial reimbursement should come from the same source of truth
 - False sense of reliance on coding.
- Clinical documentation focus - helps to bring coding closer to reality.

Data is not perfect but....

5 Stages of Grief Quality Measurement

Kübler-Ross	Shannon Sims, MD, PhD
Denial	There's not a problem
Anger	Data is <i>completely</i> wrong
Bargaining	Need different metrics
Depression	My patients are sicker
Acceptance	OK, maybe we can do better

Questions?

