



Wyoming HAI Prevention Advisory Group (WHAIPAG) Conference Call Minutes August 2nd, 2012, 1:00pm

- Emily provided four corrections/updates to the agenda.
 - 1) number 6a can be deleted as we are already making strides in that area.
 - 2) number 6b-d were ideas that were given in previous meetings, and we may want to discuss if there is any more we can or want do at this time in this particular area?
 - 3) number 7 can be deleted because at the previous WHAIPAG meeting we decided as a group to hold off on strategic planning topics until we can have a face-to-face meeting in the fall.
 - 4) addition of “1.a” to allow for any updates members would like to share with the group. This could be anything HAI related. For example, if someone is aware of new published guidelines, or articles in the paper, etc.
- Emily mentioned the US Department of Health and Human Services has updated their national HAI Action Plan specifically the chapter on long term care facilities.

The chapter is now available for public comment. Emily encouraged the group to take some time to read through it and make comments.
- Deb shared information on a new nationwide Veteran’s Administration Medical Center (VAMC) initiative focused on *Clostridium difficile* (a.k.a. CDI, or C. diff).

Within the initiative they are implementing a bundle of hand hygiene efforts, environmental cleaning, and surveillance of CDI. They are using NHSN definitions, and tracking several different categories of CDI including community onset, healthcare acquired, healthcare onset, and more. They will not be using NHSN as the data tracking system as the Veteran’s Administration has their own reporting software. Deb is still working on a proposal to use the NHSN system in order to have WY specific rates available to compare her hospital too.

Deb mentioned she would be happy to share the various tools provided through this initiative including spreadsheets. She must ask permission first and will let us know.

UPDATE: Deb has received permission to share the CDI tools from the VA Central Office. These tools have been emailed to the group. If you use them, please be sure to give credit to the US Department of Veterans Affairs.

- Ellen shared information on the CDI portion of the HAI prevention project through MPQH.

All acute care and critical access hospitals have begun reporting CDI into NHSN this month (July). Baseline 6 month data and aggregated rates will be calculated approximately in the middle of February, as hospitals have until the end of January to input data.
- Russ gave an update on the OLHS in-service, and the status of the three new forms for surveyors from CMS.

As a reminder to the group, CMS has developed three new survey worksheets/forms focusing on one important area each including: quality assessment and performance improvement (QAPI), infection control, and patient discharge planning. Each of these new forms will be pilot tested in three Wyoming facilities (one form per facility) by the end of September. Once pilot testing has been completed, the forms/worksheets will be provided to the facility as well as the WHAIPAG for dissemination across the state. Distributing the forms will hopefully be viewed as an opportunity for the hospital to perform their own self assessments in these areas prior to a surveyor coming to perform the official survey.

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Additionally, Russ and Pat Prince will be presenting the Wyoming experience with these new forms to the members of the Wyoming Hospital Association at their annual conference September 26 and 27.

- The group decided to try a new format for the post meeting evaluations. A word document with questions will be sent with the meeting minutes. Members will be able to electronically fill in their answers and email the document back to Emily for compilation and feed back at the next meeting. **Please remember to fill out the meeting evaluation document and send back to Emily by August 24, 2012.**
- Emily addressed a couple comments from the meeting evaluation from the previous meeting. One set of comments related to mandatory reporting requirements was not addressed as the person initiating the comments was not available to provide more detail. The second set of comments surrounded CDI reporting. The person was available, and most of her comments or questions were addressed through the LAN last month.
- Emily reminded the group of the main focus and purpose of these monthly WHAIPAG calls. The WHAIPAG was created to identify HAI related issues in Wyoming. These for example could be lack of training, lack of surveillance, high CAUTI rates in CAHs as compared to acute care facilities, or a multitude of other problems. The purpose of this group is also to assist in facilitating prevention projects across the state. The WAHIPAG meetings are to discuss these issues, and how to go about solving them. They are not intended to provide additional training in IP or surveillance, environmental cleaning, etc. Although if those sorts of things are needed across the state, the group can discuss how we might provide more training support such as through the LANs or creating a new collaborative or getting facilities to pledge work toward national prevention projects.
- Emily updated the group on the status of the Wyoming Department of Health HAI related website. The WHAIPAG section now contains links to each of the previous meeting minutes. We will be adding an area to either the provider section, or a new page for webinars, training materials, patient stories, and template protocols and procedure manuals. Additionally, from now on, when an infection preventionist shares a protocol or procedure manual with others on the list serve Emily will request permission to de-identify the originating facility information and post the template to the website for future use.

If you have any webinars, power points, training recordings, and/or patient stories and permission to share with others, please send them to Emily. She will pass them to Tiffany to upload or add links to the website.

- Emily updated the group on the status of the grant proposal she wrote and submitted several months ago. She expects to get fully funded; however the funds most likely will not be available for use until the end of August. Therefore, a topic of discussion for the next meeting in September will be the details of a face-to-face meeting for WHAIPAG members this fall.
- Ellen gave an update on statewide CLABSI, CAUTI and catheter utilization rates. Please see the document “WY CAUTI July Chart” as provided in the email for more details.
 - 1) No CLABSIs were reported in the state from November 2011 through April 2012. One CLABSI was reported in May 2012.
 - 2) There were 4 CAUTIs reported in ICUs from December 2011 through February 2012, but zero from March through May. This is a rate of about 1.13 CAUTI events per 1000 catheter days. There were 9 CAUTIs reported in MED-SURG/OTHER locations from December 2011 through May 2012. This is a rate of about 2.11 CAUTI events per 1000 catheter days.

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- 3) Device utilization has remained relatively stable from December 2011 through May 2012. Catheter utilization rate over the 6 months among ICUs was 0.66 (or 66%) and among MED-SURG/OTHER locations was 0.21 (21%). A national device utilization rate would be nice to find upon which to compare WY facilities.
- Deb shared a report with the group she uses to find national benchmarks. Please see the document “NHSN-Report_2010-Data-Summary” as provided in the email for more details.
- Ellen provided an update on the LAN sessions.

Last month went well and was well timed with CDI surveillance education. A patient story was created and presented with great success. Patient stories will now be a part of each LAN session. Next week two WY facilities will share what works for them with regards to staff empowerment. In September two more WY facilities will share tracking methods that have worked for them.
- Ellen provided an update on the status of hiring an intern to help the group create the electronic and word searchable infection prevention manual.

To remind the group, MPQH has some money they can use to support an intern. The primary responsibility of the intern will be the creation of the infection prevention resource manual. In the previous WHAIPAG meeting a committee was formed to create a job description, and select the intern. The job description is nearly finalized and will be sent to MPQH HR department for review and then sent to the University of Wyoming contact for dispersal to students. The intern will directly report to Ellen; however, the committee will provide direct guidance for the intern’s tasks. Members of the WHAIPAG will be solicited for any and all resources, guidelines, etc. they have that would be important to include in the resource manual. Additionally, the WHAIPAG will be tasked with reviewing it before final “publication.”
- Emily asked the group if we would like and/or could do more as a group in terms of helping facilitate nurse empowerment throughout the state or is it time to move on to something else?
 - 1) Emily mentioned a few things that have been suggested as future projects for the group in previous WHAIPAG meetings. These include conducting more surveys of other facility types to determine current HAI prevention and surveillance related practices. Another suggestion was to create and distribute more in-depth surveys of the critical access and acute care hospitals to better determine why some recommended practices are or are not in use.
 - 2) Etta brought up the issue of patient/family empowerment. They also need education.
 - 3) Baerbel brought up the issue of new nurse empowerment specifically. She and Michelle agreed that in order to empower staff nurses, it must come from senior facility leadership such as board members, CEOs, DONs, etc.
 - 4) Alicia Cole, the HAI survivor and patient advocate, whom presented her story at the Wyoming Infection Prevention Conference earlier this spring will be presenting twice at the Wyoming Hospital Association Meeting in September.
- There was a lot of discussion around changing the current culture in hospitals and healthcare to one of safety as well as nurse empowerment to speak up. Several good questions were posed to the group for thought and discussion at the next meeting.
 - 1) What could we as a group work on in terms of changing the culture of healthcare facilities that we can also monitor and see a change happen?
 - 2) How can we as a group make a difference in terms of HAI prevention and instituting a culture of safety and staff empowerment to speak up?
 - 3) What is the WHAIPAG’s ability to make a change for Wyoming citizens?
 - 4) What is your dream for the WHAIPAG?

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Please think about the above questions and come to the next meeting prepared to answer each.

- Ellen mentioned she has worked in attempting to change culture in other fields. It is often difficult to measure culture and to determine change for the better or worse. She suggested perhaps the group could put together a tool kit together or re-create the HHS interactive video for training hand hygiene, but geared toward staff empowerment. Additionally, suggestions included performing an ARC survey to measure culture, but it is very time consuming and resource intensive.

Ellen will contact HHS and Neil about tools for staff empowerment from the HREN project.

- Ellen mentioned that the Get Smart Antibiotics Week will be coming up soon: November 11-18. MPQH will be creating some marketing tools for this week, and would like ideas and input from members of the group.

If you are interested in helping to creating marketing materials for the Get Smart Antibiotics Week, please email Ellen.

- The next meeting will be **September 6, 2012 at 1pm**. Emily will be out of town. However, Ellen volunteered to host the call and Michelle volunteered to take minutes.