

C difficile Interventions in Northern California Kaiser Permanente

■ **Recognition**

- HAI Committee reviews data and makes recommendations
- Make case to Senior Leaders

■ **Accountability**

- Performance review partly based on *C diff* activities and results.
- Charged a multidisciplinary group to have a system wide intervention

C difficile Interventions in Northern California Kaiser Permanente

- **Develop Bundle- Recognized strategies**
 - Recognition and testing
 - **Reached first liquid stool recommendation**
 - Hand hygiene and isolation
 - EVS process
 - **Room cleaning**
 - **Bleach**
 - **Defined equipment responsibility**
 - Antibiotic Stewardship
 - **PPI reduction as well**

C difficile Prevention Bundle

R

Risk Reduction

Isolate at first sign infection

I

Isolation

**Contact Plus; Dedicated Equipment; PPE supplies;
Isolate until discharge**

G

Glove and Gown Etiquette

Gel before, soap after gloves; Educate pt and family

H

Hand Hygiene

Gel in, soap out; Remind each other, Response: Thank you

T

Touch – Moveable Equipment Cleaning

**Clean moveable equipment with disinfectant between pts
and with bleach before exiting Contact PLUS**

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- **Staff education and engagement**
 - Summit – 6-10 members from each facility (Quality Director, ID, IP, EVS staff, Staff nurse, CNO or similar position)
 - Roll out at each facility

Why C diff?

Because it Harms

- 79 year old woman,
- admitted 10/21 for MRSA Sepsis; 9 day hospital stay
- Readmitted 3 days later for HF; 5 day hospital stay
- Readmitted 10 days later with pulmonary embolism; 7 day hospital stay
- Readmitted 12/24 with C. difficile colitis
- Died in hospital on day 17

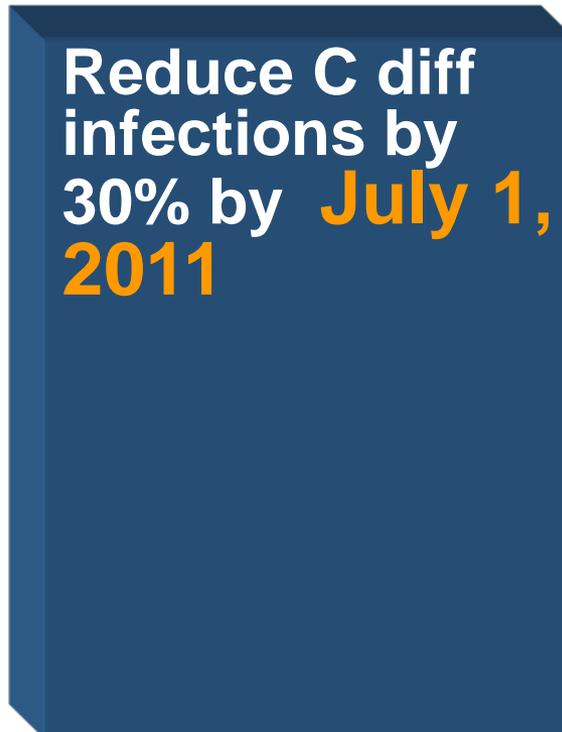
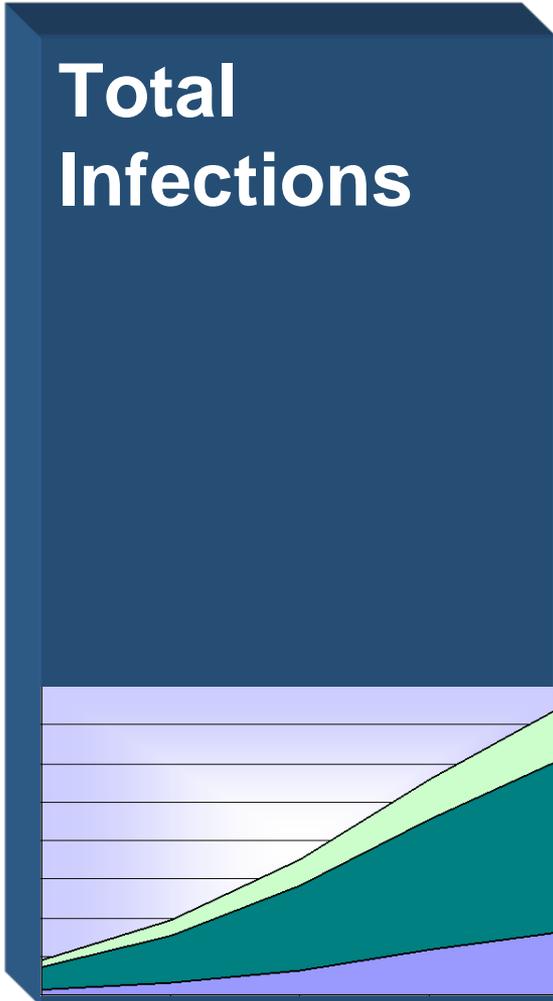


Determined to Be Different

Total Infections

Reduce C diff infections by 30% by **July 1, 2011**

Reduce C diff infections by 50% by **July 1, 2012**



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- **Monitoring**
 - Secret shoppers
 - ATP testing
 - Surveys, Pharmacist review of ABS
 - CDI rates
 - Feedback to Leaders monthly

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- **Unintended consequences and changes**
 - Unrealistically high performances
 - **Secret shoppers**
 - **Third party ATP monitoring**
 - Identification of carriers as CDI
 - **Move to 3rd watery BM**
 - **Exclude GI preps**

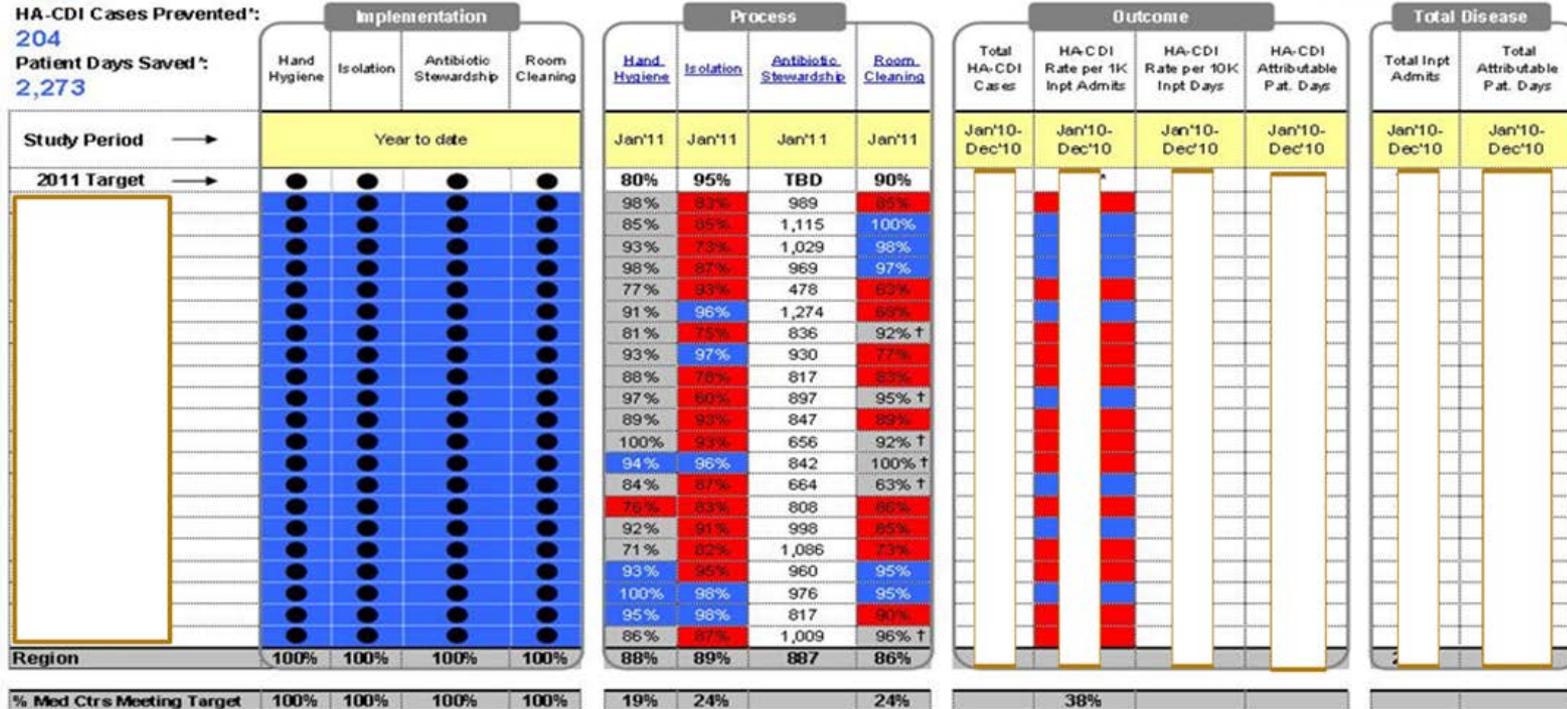
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Hospital-Associated Clostridium Difficile Infection

Metric Definitions

HA-CDI Cases Prevented*:
204
Patient Days Saved*:
2,273



* Cumulative since 1/1/2010, compared with average 2008-2009 baseline volume

** Preliminary target, subject to change pending impact assessment of regional C. diff toxin lab testing methodology redesign
Target represents 30% reduction from 2008-2009 baseline rate, to be reached in first year post-implementation (Jul'10 - Jun'11)

Grayed Hand Hygiene data represents medical centers who did not meet minimum Hand Hygiene audit criteria: n=36 audits per unit per month

† Low testing volume, less than 50% of expected monthly tests performed

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Quality and Operations Support

Northern CA HO-CDAD Rates in KP

