

Patients as Partners in the Infection Prevention and Control Process





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Printed in the U.S.A. 5 4 3 2 1

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ISBN: 978-1-59940-319-9
LCCN: 2009927947

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Introduction

According to the Centers for Disease Control and Prevention (CDC), health care–associated infections (HAIs) kill nearly 100,000 Americans each year, and an additional 2 million patients are treated for HAIs.¹ Many of these infections could be prevented if organizations followed simple infection control procedures.

Patient and family involvement is more important than ever to achieve safe and error-free patient care. To encourage this involvement, The Joint Commission created National Patient Safety Goals (NPSGs) 7 and 13, requiring organizations to define and to communicate the means for patients and their families to report concerns about safety, including infection control issues. Although organizations can comply with these goals in a number of ways, it is essential that organizations nurture cultures that involve patients and families in day-to-day opera-

tions. Through discussion, exhibits, and case examples, this new resource will teach health care providers how to create a culture of safety that accepts patients and families as part of the health care team, opening the lines of communication between patients and caregivers. This book also includes the following key features/benefits:

- The creation of patient/family education programs that teach patients how to be involved and how to recognize errors pertaining to infections
- Methods of evaluating a patient's level of health literacy
- Education and involvement needs for special patient populations, such as pediatric, geriatric, chronic, and limited English–speaking patients
- Definition and communication of the means for patients and their families to report concerns about safety and ways of encouraging them to do so

- Case examples describing what other organizations are doing to achieve, facilitate, or promote patient/family involvement in their own organizations
- Focus on NPSGs 7 and 13 and how the Joint Commission assesses a health care organization's compliance with them through the tracer methodology

Patients as Partners in the Infection Prevention and Control Process also offers simple-to-implement methods for educating caregivers and patients about infection prevention and control. It includes initiatives developed by other organizations that relate to specific topics and provides multiple examples of forms, handouts, checklists, and procedures. A detailed description of each chapter follows.

Chapter 1. Nurturing a Culture of Safety to Prevent and Control the Transmission of Infections

This chapter discusses why patient/family education is important in the infection control process. It also includes a discussion of National Patient Safety Goals, including how the Joint Commission evaluates compliance.

Chapter 2. Health Care Provider Education

Before health care providers are able to educate and encourage patients and their families to be part of the infection prevention and control process, they need to be trained on infection prevention and control practices. Chapter 2 includes information about different methods of staff education. It also includes information about the development of sustainable infection control practices and the education of staff in the following areas of infection control:

- Hand hygiene
- Surgical site infections (SSIs)
- Multidrug-resistant organisms (MDROs)
- Catheter-associated urinary tract infections (CAUTIs)
- Central line–associated bloodstream infections (CLABSIs)
- Ventilator-associated pneumonia (VAP)
- Influenza

Chapter 3. Opening the Lines of Communication Among Health Care Providers and Patients and Families

Chapter 3 includes information about methods of open communication for health care providers' interactions with patients and families. It also discusses why open lines of communication are part of the patients-as-partners philosophy.

Chapter 4. Evaluating Patients' Health Literacy

This chapter provides information about health literacy—the degree to which individuals have the capacity to obtain, process, and understand basic health information needed to make appropriate health decisions. It includes discussions about age- and developmentally appropriate communications, cultural challenges, language barriers, and comprehension/reading levels.

Chapter 5. Educating and Empowering Patients and Their Families

Chapter 5 includes information about patient education in the following areas:

- Reporting concerns
- Patient hygiene
- Food safety
- Medications
- Keeping patients, families, and staff safe
- Standard precautions
- MDROs

- HAIs
- SSIs
- CAUTIs
- CLABSIs
- VAP
- Pet safety

Online Extras

This book features additional bonus material on the Joint Commission Resources Web site, including the following:

- Articles on patient involvement and infection prevention and control from the JCR periodical *Perspectives on Patient Safety*
- An Institute for Healthcare Improvement PowerPoint presentation on methicillin-resistant *Staphylococcus aureus* (MRSA) prevention
- A “How-To Guide” from the 5 Million Lives Campaign that addresses MDROs
- A document titled “Integrating Sentinel Event Analysis Into Your Infection Control Practice” from the Association for Professionals in Infection Control and Epidemiology
- Links to additional resources

Acknowledgments

Joint Commission Resources gratefully acknowledges the time and insights of the following people:

- John M. Costello, M.D., M.P.H., assistant professor of pediatrics, Harvard Medical School, Division of Cardiac Intensive Care, Department of Cardiology, Children’s Hospital, Boston

- Angelica Flores, M.D., surveyor, The Joint Commission
- William Fore, M.D., surveyor, The Joint Commission
- Karen Martin, manager, Epidemiology, Advocate Christ Medical Center, Oak Lawn, Illinois
- Pam McCroskey, M.D., surveyor, The Joint Commission
- Lance R. Peterson, M.D., associate epidemiologist, Division of Microbiology, Department of Pathology and Laboratory Medicine, NorthShore University HealthSystem, Evanston, Illinois
- J. Renee Watson, R.N., C.I.C., manager, Infection Control/Occupational Health, Children’s Healthcare of Atlanta

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1. Centers for Disease Control and Prevention: *Estimates of Healthcare-Associated Infections*. <http://www.cdc.gov/ncidod/dhqp/hai.html> (accessed Mar. 25, 2009).

Nurturing a Culture of Safety to Prevent and Control the Transmission of Infections

Creating a culture of safety involves breaking down barriers and creating a collaborative environment in which all members of the care team—executives, administrators, clinicians, and patients and their families—treat each other as equals, regardless of job title. This team has mutual respect for and trust in each member, with the ultimate goal of ensuring patient safety and health care quality.¹

The concept is simple, but its implementation may not be. In organizations in which the focus has been on the needs of health care professionals, putting the focus back on patients may take some reevaluation and restructuring on the part of executives, administrators, and boards, as well as some self-reflection on the part of physicians, nurses, and everyone responsible for patient care. Changes in philosophy, attitude, and behavior may be required. Planning and action at every

level of the organization, including a strong commitment from leadership, will be needed to create a culture of safety.¹

Creating a culture of safety must start with executive leadership and be evident in every interaction between the organization's personnel and patients, as well as in every interaction among personnel themselves. Joint Commission Leadership standards—in particular, Standard LD.03.01.01—require that leaders create and maintain a culture of safety and quality. Safety and quality thrive in an environment that supports teamwork and respect for other people, regardless of their position in the organization. Leaders should demonstrate their commitment to quality and set expectations for those who work in the organization. They should evaluate the culture on a regular basis. Leaders should encourage teamwork and create

structures, processes, and programs that allow this positive culture to flourish.

Disruptive behavior that intimidates others and affects morale or staff turnover can be harmful to patient care. Leaders must address disruptive behavior of individuals working at all levels of the organization, including management, clinical and administrative staff, licensed independent practitioners, and governing body members.

Creating a culture of safety involves imposing personal and organizational accountability but not blame, publicly acknowledging errors either made or narrowly missed, and seeing them as opportunities to learn and to improve. According to Diane Pinakiewicz, M.B.A., president of the National Patient Safety Foundation, “Fostering a culture of safety needs to involve visionary as well as practical leadership.”¹

According to Mary Dana Gershanoff, a patient literacy advocate, when one enters a culture of safety, one knows it right away. For example, signs are posted in every room telling patients they should ask their physicians or nurses if they have washed their hands and that clinicians welcome and encourage such questions. Patients and families are treated with dignity and respect. This principal characterizes interactions among everyone in that organization. Patients and family members are encouraged to report safety concerns, and clinicians are taught to listen.¹

Change, even necessary change, can be uncomfortable, but what is the alternative? In light of the evidence² that a culture of blame, acrimony, and generally strained relations among staff members—and failure to communicate openly and respectfully with patients—contributes to medical errors, change is an essential first step in prevention.¹

Creating a “Zero Infection” Culture

Denise Murphy, R.N., M.P.H., C.I.C., vice president and chief medical and quality officer, Barnes-Jewish Hospital at Washington University Medical Center in St. Louis, has developed strategies for creating a “zero infection” culture. According to Murphy, organizations should set a goal of complete elimination of health care–associated infections (HAIs). This goal involves the following three key elements³:

1. Establish a culture of zero tolerance for not adhering to proven infection prevention measures and practice.
2. Have no tolerance for broken processes and systems that fail patients, health care teams, and communities.
3. Design safer systems that prevent harm.

According to Murphy, zero tolerance is a goal, an attitude, and a commitment. Organizations that make this commitment no longer accept benchmarks and do not stay comfortable at that level. Their target is a rate of zero HAIs.³

Part of creating this culture is treating any infection that does occur as something that should never happen. Each infection should be investigated, and root causes should be identified.³

In a zero-tolerance culture, all personnel are accountable for preventing HAIs. This does not mean that the organization responds with punitive measures to infections that may have been preventable; it means part of the organization’s mission is to find, understand, and fix the underlying problems that lead to infections.³

Some key prevention strategies organizations that have achieved or nearly achieved zero infections include the following³:

- Celebration of successes
- Nursing staff and equipment dedicated to prevention of cross contamination
- Educational programs for health care providers on infection control practices, theory, and issues
- Regular auditing of personal protective equipment compliance
- Reporting of any intensive care unit infections to staff, physicians, leadership, the health care system, and relevant committees
- Screening for infections at admission and periodically thereafter
- Strong hand-hygiene program with strict compliance
- Solid collaborative interdepartmental relationships built and fostered through continued communication

The Importance of Patient Involvement in Infection Prevention and Control

Health care professionals have known for years that patients who are actively involved in their care often enjoy better clinical outcomes.⁴ Therefore, communication with patients and their families about all aspects of their care is an important characteristic of patient safety. When patients know what to expect, they are more aware that the choices they make can affect their care, and they are more likely to catch potential errors.⁵

Modern health care, despite its great strides in preventing and treating disease, has yet to conquer the risk to patients of acquiring an infection in the very places where infection should be least present. However, infections associated with multidrug-resistant organisms (MDRO) can be acquired in almost any setting, including homes, schools, and vacant lots, making the need for effective infection prevention and control in health care organizations all the more critical.

For all the preventive steps health care professionals take, transmission of a pathogen may still occur, if not in the blink of an eye, in a quick touch of the hand or a turn of the head. Infections caused by a patient's inadvertent exposure to a friend or family member who has not practiced proper hand hygiene, for example, can lead to setbacks and potentially even death.⁶

The Centers for Disease Control and Prevention (CDC) indicates the number of people who die every year from HAIs is close to 100,000, with millions more becoming ill.⁷

Potential patient harm can be prevented with some basic actions throughout the spectrum of care, including measures taken by those both physically and figuratively closest to patients—their loved ones. According to Louise M. Kuhny, R.N., M.P.H., M.B.A., C.I.C., senior associate director of Standards Interpretation, The Joint Commission, although health care workers have a primary role in preventing infection, patients and their families also have an important responsibility.⁶

Medicare Reimbursement for Health Care–Associated Infections

Previously, more than 60% of the total national cost for treating HAIs was met by Medicare.⁸ Beginning in 2009, Medicare will no longer cover the costs of “preventable” conditions, including HAIs.⁸ Therefore, if a Medicare patient develops an HAI while being treated for something that is covered by Medicare, the extra cost of treating the HAI will no longer be paid for by Medicare.⁸ Instead, the organization where the patient developed the HAI will have to cover the costs, because the rules do not allow the organization to charge the costs to the patient.⁸