



What Is The 'Box'?

- We like rules
- We try to fix everything on our own


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Why Is The Box More Like a Trap?

- One size rarely fits all in infection control
- We end up raging against the machine


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Busting Out of The Box

- Divide into must-do, may-do, and dream of doing
- Let others own things
- Avoid the cookie cutter
- The evidence trail may not lead far


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Divide into must-do, may-do, and dream of doing

- “*You can’t boil the ocean*”
 - What can you tackle now? Tackle later? Not able to tackle?


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Divide into must-do, may-do, and dream of doing

- The list of things IPAC can do is seemingly endless
- EG
 - many levels of surveillance: adherence to FRI/GE screening; central line protocols; antibiotic protocols; CLI outcomes; SSI outcomes; VAP outcomes
 - hand hygiene audits; reprocessing audits
 - housekeeping protocols
 - OHS issues, including staff immunization
 - education


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Divide into must-do, may-do, and dream
of doing

- Some of these are non-negotiable EG outbreak investigation; ARO screening; identification of key incident nosocomial infections; policies



Divide into must-do, may-do, and dream
of doing

- Take a bird's eye view of your facility: resources (human and non-human), senior administration support
- Then consider the may-do and dream of doing
- EG education; audits; additional outcome indicators (CLI, SSI, VAP)



But What About Everything Else?

- *Let others own things!*
- Historically, IPAC has owned everything that remotely touches on 'infection control'
- But we have not generally succeeded in the 'cop' role or as one of the non-clinical services buried within the hospital org structure



But What About Everything Else?

- In order to tackle most IPAC issues, we need to change our healthcare culture...

...and this cannot be done by infection prevention and control programs alone



But What About Everything Else?

- In order to begin, you will need to:
 - Have the clear support of the senior management team
 - Form a powerful project steering committee
 - Have local champions
 - Understand what you are trying to do
 - Create a burning platform



But What About Everything Else?

- When/if these things are in place how do you make change happen?
 - Incremental steps
 - Celebrate small wins
 - Don't expect to move the earth overnight
 - Continuous quality improvement (CQI) model



But What About Everything Else?

- What is CQI?
- **Plan**
 - Collect data and establish a baseline – what is the current process doing now?
 - Identify the problem and the possible causes.
- **Do**
 - Make changes designed to correct or improve the situation.



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But What About Everything Else?

- What is CQI?
- **Study**
 - Study the effect of these changes on the situation. Collect data on the new process and compare to the baseline. Evaluate the results and then replicate the change or abandon it and try something different.
- **Act**
 - If the result is successful, standardize the changes and then work on further improvements or the next prioritized problem. If the outcome is not yet successful, look for other ways to change the process or identify different causes for the problem.



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But What About Everything Else?

- Culture change is essential and difficult
- 80% of change initiatives fail
- Requires engagement at multiple levels
- Multiple strategies
- Far too big for infection control alone



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Avoid the Cookie Cutter

- Every organization is different
- Every unit is different
- Every outbreak is different
- Every patient is different.....
- Must think through the risks and opportunities for each situation
- Trying to make one size fit all rarely works
- Can be difficult when we like rules



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The Evidence Trail

- Sometimes runs cold

CATEGORIES OF EVIDENCE QUALITY

Grade I: Evidence from at least one properly randomized, controlled trial

Grade II: Evidence from at least one well designed clinical trial without randomization, from cohort or case controlled analytic studies, from multiple time series, or from dramatic results in uncontrolled experiments

Grade III: Evidence from opinions of respected authorities on the basis of clinical experience, descriptive studies or reports of expert committees



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The Evidence Trail

- The efficacy-effectiveness gap may be very large
- We must rely on our experience and judgment to try to bridge this gap
- There are so many variables that cannot be controlled for in IPAC research, or that have an impact



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Some UHN Examples

(A) Chlorhexidine baths

- ICU at TWH rebuild
- Resulted in a near 'open ward' concept ICU
- Crowding and clutter – a disaster in waiting
- Pre-emptive use of daily chlorhexidine baths for all ICU patients
- Use in VRE positive patients
- Use in chronic MRSA patients



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Some UHN Examples

(A) Chlorhexidine baths

- Basis?
 - *Arch Intern Med 2006;166:306-312*
 - Extrapolated the results



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Some UHN Examples

(B) Universal ARO screening

- Performed risk based screening previously
- MRSA outbreak occurred on a unit that admitted 'low risk' patients
- Root cause analysis revealed an unscreened 'low risk' patient was the index case
- Our patient population is higher risk, despite risk based screening definitions – tertiary care referral centre, complex patients, specialized programs



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Some UHN Examples

(B) Universal ARO screening

- 2007 – implementation of universal screening of all admitted patients, including screening of surgical patients in pre-admit clinic
- Substantial number of positives obtained
- MRSA rates continue to decrease
- Better surgical prophylaxis
- The literature is conflicting:

JAMA 2008;299(10):1149-1157
Ann Intern Med 2008; 148:409-418



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Some UHN Examples

(C) Limitation of repeat VRE screening

- Cost for VRE screening substantial
- Many patients with numerous repeat VRE screens
- Noted that patients would screen negative and then screen positive again
- Currently, do not re-screen VRE positive patients – place in precautions and provide daily chlorhexidine baths



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Thank you!

Questions?



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