NETWORK 14
HAI/SEPSIS LAN
AND QIA REPORT
DANY ANCHIA, RN, CDN
QUALITY IMPROVEMENT COORDINATOR

Friday
October 27, 2017
OBJECTIVES

- Network Mission
- HAI LAN Overview
- CDC’s Making Dialysis Safer for Patients Coalition
- 2017 Network Projects Overview (QI Team)
- Open Discussion and Q&A
We support equitable patient- and family-centered quality dialysis and kidney transplant health care through the provision of patient services, education, quality improvement, and information management.
Six Domains of Quality Measurement Based on the National Quality Strategy

- **Care Coordination**: Promoting effective communication and coordination of care
- **Population/Community Health**: Working with communities to promote wide use of best practices to enable healthy living
- **Treatment and Prevention of Chronic Disease**: Promoting the most effective prevention and treatment practices for the leading causes of mortality, starting with cardiovascular disease
- **Patient and Family Engagement**: Ensuring that each person and family are engaged as partners in their care
- **Affordability**: Making quality care more affordable for individuals, families, employers, and governments by developing and spreading new healthcare delivery models
- **Safety**: Making care safer by reducing harm caused in the delivery of care
WHAT IS A LAN?

LANs are mechanisms by which large scale improvement around a goal is fostered, studied, adapted, rapidly spread and sustained regardless of the change methodology, tools, or time-bounded initiative that is used to achieve the goal.

LANs seek to engage communities around an action based commitment(s) towards the achievement of person-centered outcome/goal.
C.4.1.B. Participate in the ESRD NCC HAI LAN

The ESRD NCC HAI LAN has two primary purposes. **The first is to improve information communication across care settings**, with emphasis on communication between hospitals and dialysis centers caring for the same ESRD patients. **The second is to increase awareness of and implementation of CDC Core interventions**

Include:
QIN-QIO(s), HIINs, state/local health departments, State Survey Agencies, long-term care facilities, hospitals, **ALL** dialysis facilities including regional leadership, and patient representatives to support communication and the BSI QIA
CMS Expectations:

- All facilities are encouraged to participate
- ID facilities that have successfully implemented all of the CDC Core Interventions and have had no infections reported in NHSN for a minimum of 6 months
- Attend the ESRD NCC HAI LAN every other month
- Share interventions and best practices to improve BSI rates
- Encourage providers to discuss CDC Core Interventions during QAPI meetings

We Need You!!!
Network 14 is a partner of this coalition. Our commitment includes the following goals and activities:

- Use Coalition messages and materials to publish editorials, blogs, articles, and/or organizational emails on infection prevention topics
- Launch a social media campaign featuring Coalition messages
- Place the Coalition button, materials and resources on our website, www.esrdnetwork.org
- Link to the CDC Core Interventions and Guidelines and Coalition materials and resources from our website
- Promote the Coalition’s purpose and material through the Network 14 HAI LAN
- Participate in Coalition calls and webinars to obtain the newest infection prevention information for CDC and dialysis experts
- Promote and use CDC continuing education (CE) course/training for health care providers in the Network
- Provide Coalition materials to patients and encourage them to speak up about infection prevention
- Promote the use of CDC Core Interventions and Guidelines in our Infection Detection Quality Improvement Activity which is focused on decreasing bloodstream infections
- Deliver presentations to interested parties
- Facilitate sharing of bloodstream infection prevention experiences among Network facilities
The Making Dialysis Safer for Patients Coalition aims to:

- Facilitate implementation and adoption of core interventions through promotion, dissemination, and use of audit tools, checklists, and other resources;
- Increase awareness about the core interventions for dialysis bloodstream infection prevention through educational efforts; and
- Share experiences and findings through collaboration with other Coalition participants.

The benefits of joining the Coalition include:

- Access to infection prevention materials and CDC expertise;
- Networking opportunities with other Coalition participants; and
- Recognition as a partner of CDC in this important effort.
To Join you can go to the following website:

https://www.cdc.gov/dialysis/coalition/
2017 VASCULAR ACCESS MANAGEMENT

AIM 1: Better Care for the Individual through Patient and Family Centered Care

- **DOMAIN:** Vascular Access Management
- **SUB-DOMAIN:** Reduce Catheter Rates for Prevalent Patients
- **QIA Components**
  - Baseline derived from September 2016 CROWNWeb data
  - 240 facilities with LTC rate >10%, categorized into 2 groups:
    - Group A: LTC rates =/> 15%
    - Group B: LTC rates >10 but no greater than 15%

- **New in 2018**
  - LTC will be part of the BSI QIA
<table>
<thead>
<tr>
<th>Group</th>
<th># Fac</th>
<th>Interventions</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>A: Facilities with a LTC rate $\geq 15%$ at baseline</strong></td>
<td>74 (75)</td>
<td>Network facility notification of facility LTC rate of $&gt;15%$ at baseline. Facilities <strong>required</strong> to complete Root cause Analysis. Facilities will be monitored for detection of untoward trends with their LTC rate. An untoward trend is defined as a focus facility with a LTC of 15% or more for 3 consecutive months. Should this occur, the facility will be required to update/develop an action plan and have Medical Director sign off on it. <strong>Monthly coaching calls</strong> are required for all facilities in Group A as well as <strong>LTC Monthly Reports</strong>.</td>
</tr>
<tr>
<td><strong>B: Facilities with LTC rate $&gt; 10%$ at baseline but no greater than 15%</strong></td>
<td>166 (165)</td>
<td>Complete a facility specific root cause analysis via survey monkey in order to identify the most common reason(s) for LTC use. Facilities with LTC rates $&gt;10%$ will be monitored monthly. If LTC rates within any of these facilities show an untoward trend (i.e., reach 15% or more for 3 consecutive months), interventions for the facility will be developed including moving facility into Group A and initiation of one-on-one coaching calls. Monthly calls are not required for facilities in group B otherwise. <strong>LTC Monthly Reports</strong> required.</td>
</tr>
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</table>
### GROUPS AND INTERVENTIONS

<table>
<thead>
<tr>
<th>Group</th>
<th># Fac</th>
<th>Interventions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bloodstream Infection (BSI) QIA Crossover</td>
<td>48</td>
<td>Facilities enrolled on both QIAs will still complete interventions required for both QIAs.</td>
</tr>
<tr>
<td><strong>Rationale:</strong></td>
<td></td>
<td>These facilities will benefit from being involved in both the CORE QIA and BSI QIA interventions as reducing catheter use leads to a reduction in catheter infections</td>
</tr>
<tr>
<td>All Facilities</td>
<td></td>
<td>Site visits:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Will be conducted anytime and as needed. i.e., facility has compliance issues or needs onsite support and guidance.</td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>Update:</strong> 6 site visits completed in May (South Texas, Houston, and Tarrant County) followed up by post-visit letter and a MD VA Self-Assessment.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>VA Newsletter: Fax blast, email, webpage.</td>
</tr>
</tbody>
</table>
GROUPS AND INTERVENTIONS

Total of 469 One-on-one coaching calls completed from Feb 21-August 2017

Questions & Issues Addressed

- Name and title of attendees and their VA role
- Is there a VA manager with back-up? If not then get one ASAP
- Review of LTC Monthly Report which includes percentage of AVFs, AVG, and CVCs <= 90 days
- Review process for referrals and follow up for VA
- Asked if facility currently has a process for initiation of permanent access pre-dialysis (i.e., in the hospital before patient gets discharged to be admitted to their facility)
- Utilization of the ESRD Forum MAC Catheter Reduction Toolkit
- FPR or Pt. champion involvement

One-on-One Coaching Calls Completed From Feb to August

[Graph showing coaching calls by month and date]

- 20 Calls (Jan-17)
- 56 Calls (Feb)
- 65 Calls (Mar)
- 54 Calls (Apr)
- 63 Calls (May)
- 80 Calls (Jun)
- 81 Calls (Jul)
- 50 Calls (Aug)
- 8 calls (Sep)

LTC Rate

2017 Goal
# BEST PRACTICES

<table>
<thead>
<tr>
<th><strong>LD01</strong></th>
<th><strong>LD02</strong></th>
</tr>
</thead>
</table>
| - Regional VA Coordinator  
- Weekly meetings with VA team  
- Attends NW Monthly calls  
- Utilize NW recommended tools  
- Utilize FPRs as pt liaison | - Regional VA Coordinator  
- Monthly Outcome Review with IDT, Clinical Specialist and ROD  
- Weekly CVC Champ calls with clinic VA Managers |

<table>
<thead>
<tr>
<th><strong>19 Facilities</strong></th>
<th><strong>71 Facilities</strong></th>
</tr>
</thead>
</table>
| - 17.74% at Baseline  
- 12.60% by end of July | - 22.85% at Baseline  
- 18.62% by end of July |

**5.15% Improvement**  
**4.23% Improvement**
LTC Cohort 240 Facilities with >10% at baseline
Goal = 2% reduction by Sep 2017

DIF and IQI DB starts with Dec 2016 for monthly

Last Year 2016
LTC Cohort 233 Facilities with >10% LTC at baseline

Intervention Period

No Data
Overview SOW Requirements

- Increase Hepatitis B and Pneumococcal Pneumonia Vaccination Rates by a minimum of 3 percentage points in 2017 (2% last year)
- ≥10% of low-performing facilities (Max: 25 facilities)
- *Stay in project until reaching 60% vaccination rates for both vaccines
  - *22 facilities rolled over and 3 graduated from 2016

- Vaccinations QIA: removed as single project for 2018
ESRD Network 14 overall vaccination rate: 54.7%
  - Hepatitis B average vaccination rate: 65.3%
  - Pneumococcal average vaccination rate: 37.2%

22 Focus Facilities in this project: 33.3%
  - Hepatitis B vaccination rate: 37.7% (*16.6%)
    - Target rate: 40.7% (3 percentage point increase)
  - Pneumococcal vaccination rate: 28.8% (*3.5%)
    - Target rate: 31.8% (3 percentage point increase)

*2015 rates
PROJECT OVERVIEW

INTERVENTIONS

### Phase 1
- **Webinar 1** – Thursday Jan 26
  - **Intervention 1**: Review Sustainability Plan submitted in 2016
- **Deadlines**
  - Feb 2: Webinar 1 Attestation
  - Feb 10: Have a progress report on sustainability and submit to Network 14

### Phase 2 – RCA & Data Errors
- **Intervention 2**: Data Correction and Root Cause Analysis
- **Deadlines**
  - March 1: RCA due
  - March 1: Initiate CROWNWeb/data corrections based on RCA

### Phase 3 – Interventions & Resources
- **Webinar 2** – Thursday March 16
  - **Intervention 3**: Review Interventions and Available Resources (Vaccination Discussion Groups, RCA, Awareness Campaigns, Data Validation Tools, etc.)
- **Deadlines**
  - March 23: Webinar 2 Attestation
  - March 31: Intervention Summary due to the Network

### Phase 4 – Verify and Sustain Improvements
- **Webinar 3** – Tentative June
  - **Intervention 4**: Data Validation and Sustainability Initiatives
- **Deadlines**
  - June (TBD): Webinar 3 Attestation
  - July: Meet project goal
Baseline and 2016-2017 Monthly HBV Rate in Focus Facilities &
Overall Network HBV Rate at Baseline
Baseline Data: 2016 data, Data Source: HAI Vaccination data from NCC
Baseline and 2016-2017 Monthly Pneumococcal Vaccination Rate in Focus Facilities & Overall Network Pneumococcal Rate at Baseline

Baseline Data: 2016 data, Data Source: HAI Vaccination data from NCC

- **Pneumo Rate**
- **NW Goal 3% Improvement (31.8%)**

<table>
<thead>
<tr>
<th>Month</th>
<th>Vaccination Rate</th>
</tr>
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<tbody>
<tr>
<td>Aug-16</td>
<td>28.8%</td>
</tr>
<tr>
<td>Sep-16</td>
<td>50.8%</td>
</tr>
<tr>
<td>Oct-16</td>
<td>53.7%</td>
</tr>
<tr>
<td>Nov-16</td>
<td>54.4%</td>
</tr>
<tr>
<td>Dec-16</td>
<td>55.7%</td>
</tr>
<tr>
<td>Jan-17</td>
<td>60.3%</td>
</tr>
<tr>
<td>Feb-17</td>
<td>63.2%</td>
</tr>
<tr>
<td>Mar-17</td>
<td>65.1%</td>
</tr>
<tr>
<td>Apr-17</td>
<td>67.3%</td>
</tr>
<tr>
<td>May-17</td>
<td>67.1%</td>
</tr>
<tr>
<td>Jun-17</td>
<td>68.5%</td>
</tr>
<tr>
<td>Jul-17</td>
<td>70.8%</td>
</tr>
</tbody>
</table>
OVERALL BASELINE & RESULTS TO DATE

Baseline and Monthly Average Vaccination Rates in Focus Facilities &
Overall Network Average Vaccination Rate at Baseline
Baseline Data: 2016 data, Data Source: HAI Vaccination data from NCC

Average Vaccination Rate  NW Average vaccination Rate at Baseline 54.7%

Vaccination Rate

33.3%  53.1%  55.3%  56.1%  57.0%  60.5%  62.2%  63.8%  65.4%  65.1%  67.2%  69.1%

Aug-16  Sep-16  Oct-16  Nov-16  Dec-16  Jan-17  Feb-17  Mar-17  Apr-17  May-17  Jun-17  Jul-17
AIM 1

**DOMAIN:** Better Care for the Individual through Patient and Family Centered Care

**SUB-DOMAIN:** Infections (HAIs)

**Reduce rates of dialysis events (HAI/bloodstream infection (BSI)/Sepsis)**

- Demonstrate a 5% or greater relative reduction in the pooled mean rate at re-measurement compared to previous year
- 20% of Network 14 facilities with the highest BSI Rates, with an oversampling to account for possible attrition (Total number of facilities = 114)
Interventions:

- Monthly CDC activities and education over the nine core interventions for BSI Prevention
  - Videos
  - Website links
  - NHSN reports for staff to review and share
  - Monthly feedback on how facility utilized tools
## DECREASING BLOOD STREAM INFECTIONS

<table>
<thead>
<tr>
<th><strong>MARCH</strong></th>
<th><strong>APRIL</strong></th>
<th><strong>MAY</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><img src="image1" alt="Patient Safety Awareness Week" /></td>
<td><img src="image2" alt="Patient Experience Week" /></td>
<td><img src="image3" alt="Clean Hands Count" /></td>
</tr>
<tr>
<td><strong>March 12-18</strong></td>
<td><strong>April 24-28</strong></td>
<td><strong>May 5</strong></td>
</tr>
<tr>
<td>Shared facility’s BSIs and other dialysis events rates with patients using the CDC’s Conversation Starter</td>
<td>Discussed facility’s policy for chlorhexidine or alternative use with patients</td>
<td>Used the CDC’s Conversation Starter to share with patients important hand hygiene practices (links to the CDC’s Clean Hands Count Campaign site)</td>
</tr>
</tbody>
</table>
DECREASING BLOOD STREAM INFECTIONS

Patient Choice by Monthly Activity

- MARCH: 16% (Patient Safety Awareness Week)
- APRIL: 4% (Patient Experience Week)
- MAY: 60% (World Hand Hygiene Day)

N = 114 BSI QIA Facilities
Top Education Methods used during World Hand Hygiene Day

- Bulletin Board: 31%
- Inservice/Homeroom: 32%
- Patient Education (one to one, groups): 34%
- Handouts: 36%

N = 114 BSI QIA Facilities
CDC’S CONVERSATION STARTER TO PREVENT INFECTIONS IN DIALYSIS PATIENTS

Conversation Starter to Prevent Infections in Dialysis Patients

How does this facility involve patients and their families in infection control activities? Are patients encouraged to speak up when they see a concerning practice (for example, a staff member who does not wash their hands)?

Dialysis centers should educate and empower patients to help prevent infections and support a safe care environment. Talk to your staff, staff member or facility administrator for ideas on how you can get involved.

How can the facility make sure that all patients receive necessary vaccines to prevent illness such as hepatitis B, seasonal flu, and pneumococcal infections?

Patients on dialysis have weakened immune systems and should get certain vaccines to keep them getting sick.

How can the facility make sure that dialysis center staff are vaccinated against the flu every year?

Staff members can spread the flu to patients. Requiring dialysis center staff to get a flu shot, and you can track their progress. Dialysis centers should also have policies in place to help patients get vaccinated.

Does this facility check all patients for hepatitis C infection?

All hemodialysis patients should be tested for hepatitis C when they start treatment at a center, and every 2 years in months that they would become infected. Testing is the only way to know if patients have hepatitis C and to find out if the infection is spreading in the facility.

Does this facility prepare medications in a separate room away from dialysis machines to avoid contamination?

Medication machines should be kept separate so that medication treatment areas do not contaminate patients' dialysis furniture. Information about medication safety can be found at www.medicationcamp.org.

To learn more visit www.cdc.gov/dialysis

We Make Dialysis Safer for Patients

AAKP

Making Dialysis Safer

Our patients are encouraged to start a conversation today!

Learn more at www.cdc.gov/dialysis/patient

Infection Detection

End Stage Renal Disease Network of Texas

Insert organization's name here.

HAS USED THE

CONVERSATION STARTER TO PREVENT INFECTIONS IN DIALYSIS PATIENTS

For more information, visit www.cdc.gov/dialysis

AAKP

Making Dialysis Safer

Our patients are encouraged to start a conversation today!

Learn more at www.cdc.gov/dialysis/patient

Infection Detection

End Stage Renal Disease Network of Texas
HOW USEFUL WOULD THE CDC'S CONVERSATION STARTER BE FOR OTHER FACILITIES TO USE?

- Answered: 98
- Skipped: 2

- Extremely useful: 28.57%
- Very useful: 43.88%
- Moderately useful: 24.49%
- Slightly useful: 2.04%
- Not at all useful: 1.02%
HOW LIKELY ARE YOU TO RECOMMEND THE USE OF THE CDC'S CONVERSATION STARTER TO A COLLEAGUE OR FACILITY STAFF?

- Answered: 97
- Skipped: 3
AS A RESULT OF REVIEWING THE CONVERSATION STARTER WITH YOUR PATIENTS...

WERE THEY MORE LIKELY TO ASK FOLLOW UP QUESTIONS ABOUT OTHER TOPICS OR CONCERNS?

- Answered: 55  Skipped: 0

WERE THEY MORE LIKELY TO BE ENGAGED IN THEIR CARE?

- Answered: 45  Skipped: 10
WILL YOU CONTINUE USING THE CDC’S CONVERSATION STARTER WITH YOUR PATIENTS AFTER THE NETWORK’S BSI PROJECT HAS ENDED?

- Answered: 44  Skipped: 11

- Yes 65.91% (29)
- If requested by patients 4.55% (2)
- On as needed basis 29.55% (13)
DECREASING BLOOD STREAM INFECTIONS

CDC Resources: https://www.cdc.gov/dialysis/coalition/resource.html
DECREASING BLOOD STREAM INFECTIONS

Quarterly Pooled Mean BSI Rate

Semi-Annual Pooled Mean BSI Rate

Project 5% RI Target = 1.19

END STAGE RENAL DISEASE
NETWORK OF TEXAS
Background

- Facilities are required to report infections identified in the facility as well as those that occurred on the 1st and 2nd day of hospital admission
- Gaps in BSI reporting to NHSN
- Insufficient/ lack of communication between hospital and dialysis facility

Goals of NHSN Data Quality QIA

- Improve communication between hospitals and dialysis facilities
- Ensure appropriate, sufficient and timely information exchange occurs between the hospitals and dialysis facilities
- Demonstrate a 1% increase from the baseline in the Positive Blood Culture (PBC) rate as expressed by the number of PBC’s by a dialysis facility reported to NHSN that occurred on the 1st or 2nd day of hospital admission
AIM 3: Reduce Costs of ESRD Care by Improving Care

- Domain: Support for facility Data Submission to NHSN
- QIA Components
  - Three cohorts of ≥20 dialysis facilities and ≥5 corresponding hospitals during a period of 5 years
  - For each cohort, the QIA will consist of
    - 1 year of planning
    - 1 year of implementation
    - Up to 3 years of monitoring
  - Five hospitals that receive patients from the dialysis facilities in the project
REHOSPITALIZATION

- ESRD patients hospitalized nearly twice per year and 30% are re-hospitalized within 30 days of discharge
- Average length of stay is 11 days per patient year
- 40% of total Medicare expenditures attributed to hospitalization
- Proportion of patients aged 66 & older discharged alive from the hospital who either were rehospitalized or died within 30 days of discharge, by kidney disease status as of 2014

Proportion of hemodialysis patients with cause-specific re-hospitalizations within 30 days of discharge, by cause of index hospitalization, 2014

Data Source: Special analyses, USRDS ESRD Database. Period prevalent hemodialysis patients, all ages, 2014, unadjusted. Includes live hospital discharges from January 1 to December 1, 2014. Cause-specific hospitalizations are defined by principal ICD-9-CM codes. See Vol. 2, ESRD Analytical Methods for principal ICD-9-CM diagnosis codes included in each cause of hospitalization category. Abbreviations: CVD, cardiovascular disease; ESRD, end-stage renal disease; rehosp, rehospitalization; VA, vascular access.
<table>
<thead>
<tr>
<th>Root Causes</th>
<th>Number of Responses</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>HOSPITAL FACTORS</strong></td>
<td></td>
</tr>
<tr>
<td>No/limited knowledge of the structure and function of the hospital EMR</td>
<td>4</td>
</tr>
<tr>
<td>No designated hospital personnel to contact to retrieve information on PBC</td>
<td>10</td>
</tr>
<tr>
<td>Key information of PBC and specifically the day of collection following the procedure</td>
<td>17</td>
</tr>
<tr>
<td>Retrieval of information from EMR is difficult</td>
<td>13</td>
</tr>
<tr>
<td>No / limited access to hospital electronic medical records (EMR)</td>
<td>12</td>
</tr>
<tr>
<td><strong>NHSN FACTORS</strong></td>
<td></td>
</tr>
<tr>
<td>Lack of facility data validation into NHSN</td>
<td>4</td>
</tr>
<tr>
<td>Reporting is time consuming</td>
<td>5</td>
</tr>
<tr>
<td>There is a learning curve for NHSN application of NHSN Dialysis Events</td>
<td>11</td>
</tr>
<tr>
<td>Individual dialysis staff access to NHSN through SAMS registration</td>
<td>12</td>
</tr>
<tr>
<td><strong>ORGANIZATIONAL FACTORS</strong></td>
<td></td>
</tr>
<tr>
<td>Not involving patients in the design, development and implementation of the protocol</td>
<td>3</td>
</tr>
<tr>
<td>Lack of incentives for communicating with hospital and ED staff</td>
<td>8</td>
</tr>
<tr>
<td>There is no clear designation of NHSN roles for facility personnel</td>
<td>9</td>
</tr>
<tr>
<td>No process for validating the data reported to NHSN</td>
<td>7</td>
</tr>
<tr>
<td>No tracking system for monitoring PBC and reporting in NHSN</td>
<td>7</td>
</tr>
<tr>
<td>There is no protocol for asking and documenting the patients about the procedure</td>
<td>6</td>
</tr>
<tr>
<td>There is no protocol for hospital/ED record retrieval process</td>
<td>8</td>
</tr>
<tr>
<td><strong>PATIENT FACTORS</strong></td>
<td></td>
</tr>
<tr>
<td>Patient/Family unaware of importance of communicating transitions of care following the procedure</td>
<td>20</td>
</tr>
<tr>
<td>Cultural differences</td>
<td>4</td>
</tr>
<tr>
<td>Language barrier</td>
<td>10</td>
</tr>
<tr>
<td><strong>FACILITY FACTORS</strong></td>
<td></td>
</tr>
<tr>
<td>General misconception that reporting guidelines for NHSN and PBC are not followed</td>
<td>8</td>
</tr>
<tr>
<td>Not following protocol and/or no protocol</td>
<td>8</td>
</tr>
<tr>
<td>Lack of staff knowledge regarding the DE protocol and application of the protocol</td>
<td>12</td>
</tr>
<tr>
<td>Lack of follow-up from dialysis facility on getting information from the hospital/ED</td>
<td>11</td>
</tr>
<tr>
<td>Lack of follow-up from dialysis facility on getting information from the patients</td>
<td>7</td>
</tr>
<tr>
<td>Lack of staff training on how to retrieve information from the hospital/ED</td>
<td>12</td>
</tr>
<tr>
<td>Time constraints</td>
<td>7</td>
</tr>
<tr>
<td>Staffing issues: Short staffed, stress, turnover, Not enough staff who are trained</td>
<td>7</td>
</tr>
</tbody>
</table>

**Number of Responses**

N = 22
No / limited access to hospital electronic medical records (EMR)

Retrieval of information from EMR is difficult

Key information of PBC and specifically the day of collection following the hospital admission is not routinely...

No designated hospital personnel to contact to retrieve information on PBC

No or limited knowledge of the role and responsibilities of different departments in hospital

No / limited knowledge of the structure and function of the hospital EMR

Number of Responses

N = 22
RESULTS

Percent Positive Blood Culture Rate
as identified on 1st or 2nd day of hospitalization
Data Source: NHSN, N=22 facilities

Baseline (1/16-6/16) 20.6%
Interim (7/16-12/16) 22.4%
Final (1/17-6/17) 29.1%
Goal 21.6%
RESOURCES

- CTSE- Council of State and Territorial Epidemiologists

- Website
  - http://www.esrdnetwork.org/professionals/
  - http://www.esrdnetwork.org/quality-improvement-activities-qia

- Transitions of Care toolkit
  - http://www.esrdnetwork.org/sites/default/files/transitions%20of%20care%20toolkit%202017%20FINAL.pdf
HAI RESOURCES

esrdnetwork.org

Resources for Professionals

Facility Interest Form

Association for Professionals in Infection Control & Epidemiology (APIC)

APIC Elimination of Infections in Hemodialysis

Centers for Disease Control and Prevention (CDC)

Making Dialysis Safer for Patients Coalition

Conversation Starter to Prevent Infections in Dialysis Patients

Conversation Starter to Prevent Infections in Dialysis Patients

CDC Announces New Dialysis Infection Prevention Resources - September 2013

- KCER Announcement
- Provider Poster
- Patient Pocket Guide

- Introduction to CDC Dialysis Collaborative
- CDC Dialysis Collaborative Flyer
- CDC Dialysis Core Interventions
- CDC Central Venous Catheter Guidelines – 2011
- CDC Clinical Education - Dialysis Safety
- CDC Clinical Guide- Get Smart for HealthCare
- CDC Staff Competencies - Collaborative - Dialysis
- CDC Protocol for Hand Hygiene and Glove Use Observations Collaborative
- CDC Catheter Exit Site Care Checklist
- CDC Catheter Exit Site Care Audit Tool
- CDC Catheter Connection Checklist
- CDC Catheter Connection - Disconnection Audit Tool
- Environmental Surface Disinfection in Dialysis Facilities – Notes for Clinical Managers
- Dialysis Station Routine Disinfection Checklist

Centers for Medicare & Medicaid Services

- CFMC QIO HAI Toolkit

U.S. Department of Health & Human Services

- HAI Initiative Webpage
- World Health Organization (WHO)
WEBINAR EVALUATION AND Q&A

Comments/Questions???

Evaluation  https://www.surveymonkey.com/r/5HJSYCY

Quality Improvement Department

- **QI Director**
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