



Practice forum

A pragmatic approach to infection prevention and control guidelines in an ambulatory care setting



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The vast majority of infection prevention and control (IPAC) experience and practice guidance relates to the inpatient setting. We have taken a pragmatic approach to applying IPAC guidance in our ambulatory setting, and here we identify and describe the 4 key areas where we modified our IPAC program and adapted current guidelines to fit with our setting.

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Women's College Hospital (WCH) is an academic health care facility in Ontario, Canada, with a primary focus on the health of women. WCH transitioned from an acute care hospital to an ambulatory care hospital during 2006. The transition of infection prevention and control (IPAC) practices from an acute care approach to an approach appropriate to ambulatory care has been gradual but determined.

The vast majority of IPAC experience and practice guidance relates to inpatient settings. The Centers for Disease Control and Prevention,¹ Public Health Agency of Canada,² World Health Organization,³ College of Physicians and Surgeons of Ontario,⁴ and Provincial Infectious Diseases Advisory Committee⁵ all publish IPAC guidance documents but provide little concrete direction for ambulatory care settings. As a result, until recently, we loosely adapted inpatient practices to fit our ambulatory setting.

In light of this, we conducted an extensive review of our IPAC program in 2011, evaluating where gaps existed and identifying where practice changes were needed to fit our new reality. We also consciously moved to a less rigid, more pragmatic approach to applying IPAC guidelines in our setting. In this report, we identify and describe the 4 key areas where we modified our program and adapted current guidelines, specifically screening and surveillance, isolation practices and personal protective equipment (PPE) use, environmental cleaning, and hand hygiene (Table 1).

SCREENING AND SURVEILLANCE

In contrast to inpatient settings, the antibiotic resistant organism (ARO) status of patients is largely unknown in standalone ambulatory care settings. Laboratory turnaround times are critical for preventing ARO transmission amongst inpatients.⁶ When WCH was an inpatient facility, this was achieved by patient ARO screening upon admission and immediate telephone calls to IPAC when a positive laboratory result was received. As we transitioned into an ambulatory care setting, ARO screening became moot because patients would visit and leave the hospital within a day, long before results were available. Therefore, we worked with the laboratory to stop immediate ARO reporting by telephone. In a few of our clinical areas, we also eliminated ARO screening for the purpose of implementing IPAC measures and encouraged screening only for clinical decision-making purposes such as choosing the appropriate perioperative antimicrobial prophylaxis.

Because it is difficult to attribute a patient infection to a health care encounter in an ambulatory care setting, we do not formally track and publicly report infection rates. Instead, we have focused our efforts on public health reporting of communicable diseases and process surveillance of IPAC practices within our hospital, such as promoting good respiratory etiquette, improving compliance with antibiotic prophylaxis guidelines, and ensuring the use of a surgical safety checklist.

ISOLATION PRACTICES AND PPE USE

Despite understanding that Routine Practices (RP)⁷ (ie, Centers for Disease Control and Prevention standard precautions) should

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Table 1
Key areas differing in approach to infection prevention and control (IPAC) in an ambulatory care setting

Area	Inpatient care	Ambulatory care
Screening Surveillance	Patients are screened upon admission to implement AP Larger focus on outcome surveillance; infection rates for AROs such as MRSA and <i>Clostridium difficile</i> are tracked	Patients are not screened for IPAC purposes Difficult to attribute causation and track infection rates. Main focus is on process surveillance such as antibiotic prophylaxis and use of a surgical safety checklist
Isolation precautions and PPE use	AP are implemented, which include specific strategies for patient placement, use of PPE, and environmental cleaning	Emphasis on use of RP for all patients, including patients with a known ARO
Environmental cleaning	Daily and terminal cleaning for patient rooms. Terminal cleaning required for patients identified with an ARO	Focus on cleaning patient equipment between use and a thorough end-of-day room cleaning for all patients, including patients with a known ARO
Hand hygiene	Patient environment is well defined in the moments for hand hygiene. A direct observer can monitor hand hygiene at ease	Patient environment is less defined in the moments for hand hygiene Direct observer for monitoring hand hygiene raises numerous issues Alternative methods such as engaging patients as observers have been effective

AP, Additional Precautions; ARO, antibiotic resistant organism; MRSA, methicillin-resistant *Staphylococcus aureus*; PPE, personal protective equipment; RP, Routine Practices.

be applied to all patients at all times, staff members often relied on the patient flagging system to guide practice. Before becoming an ambulatory care hospital, WCH screened inpatients for AROs and patients who were positive for an ARO were identified with an electronic flag. When a patient was flagged for an ARO, there would be heightened attention to perform hand hygiene, use PPE (often in excess), and ensure appropriate environmental cleaning. Because of this, adherence to RP for patients not flagged with an ARO was often lax.

To provide clarity and address the inconsistent use of RP and Additional Precautions (AP),⁷ we revised our policy to emphasize the systematic application of RP for all patients, including patients known to be carrying an ARO. For staff, this meant that ARO status does not automatically necessitate AP; instead, it would depend on the risk of exposure to uncontained secretions. Finally, to further prevent the selective use of RP, we are in the process of deactivating the ARO flagging option in our patient record system.

ENVIRONMENTAL CLEANING

The cleaning practices for patients and hospital environments are not as well defined in an ambulatory care setting. Generally, because outpatient visits create less environmental contamination, less intensive cleaning is needed compared with an inpatient setting. At WCH, there have often been misconceptions regarding what needs to be cleaned and how frequently; RP for environmental cleaning were often only focused on ARO-positive patients. To facilitate cleaning, ARO-positive patients would be scheduled as the final visit of the day and then a so-called terminal clean would be performed. These practices posed a risk because RP for environmental cleaning were not being applied to all patients.

In 2012, we discontinued these practices and engaged the frontline staff, clinical managers, and clinical directors to allocate adequate resources to ensure that routine practice environmental cleaning could be applied to all patients. We also emphasized that special cleaning by environmental services was no longer required for ARO-positive patients if there was no visible soiling of the environment. We explained that with diligent use of RP, ARO-positive patients could be scheduled at any time. An audit conducted April 2013-December 2013 confirmed that 97% of frontline staff (N = 67) were following this policy and cleaned patient equipment between uses. Lastly, best practices for environmental cleaning in an inpatient setting include specific guidelines on daily and terminal cleaning of patient rooms.⁸ With no patients requiring discharge or transfer from our hospital, we shifted from the concepts of daily and terminal cleaning to applying RP of environmental cleaning between patient visits and thorough cleaning at the end of each day.

HAND HYGIENE

Until recently, there have been few resources addressing specific hand hygiene practice guidelines for an outpatient setting. Since 2008, the WCH approach to hand hygiene practices has been based on the program developed by the Ontario Ministry of Health and Long-Term Care.⁹ This program was created primarily to help inpatient facilities improve health care worker hand hygiene compliance. Therefore, we found that applying the moments for hand hygiene in an ambulatory care setting required adaptations. We had to redefine the patient environment and focus on the concept of performing hand hygiene at the point-of-care in a clinic room. Although the Hand Hygiene Human Factors Toolkit issued by the Canadian Patient Safety Institute¹⁰ recommends installing alcohol-based hand rub dispensers by the door inside and outside a patient room, we chose to focus resources on ensuring that, at a minimum, alcohol-based hand rubs are provided at the point-of-care; that is, on a health care provider's desk or within reach of exam bed areas. As a result of this work, hand hygiene compliance before contact with patients or patient environments increased from 80%-93% during the period 2010-2013.

In accordance with best practices for monitoring hand hygiene,^{3,11,12} WCH began monitoring hand hygiene practices by direct observation. However, adapting this approach to our clinical areas proved difficult because most patient visits involve 1 patient and 1 health care provider in a private examination room. To observe practices meant that an auditor would have to be present in the same room as the patient and health care provider. Not only was this highly uncomfortable for all involved, but it also raised concerns related to patient privacy and workflow disruption. Moreover, the Hawthorne effect would have significantly biased the results for health care providers' hand hygiene compliance. Compounding the challenges was the fact that the direct observer method was labor-intensive because few hand hygiene indications were observed during a typical patient visit lasting 15-30 minutes.

To address these challenges, we instituted an alternative method for hand hygiene monitoring that was inspired by an approach described by Bittle and LaMarche.¹³ This method engages patients to observe their health care providers' compliance to hand hygiene. We invited patients to complete a survey card after their visit with their health care provider. During the pilot program, patients returned 75.1% of the survey cards distributed, and overall hand hygiene compliance was 96.8%. The accuracy/interrater reliability of patient observations were determined to be in concordance with an independent observer 87% of the time, suggesting that patients were generally able to correctly evaluate health care provider hand hygiene practices. Based on these results, we concluded that engaging patients as observers is an effective

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