



IP&C in a Home Care Setting: A CSI Approach to Standard Based Practice.

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Objectives

- Identify the IP&C challenges in home care (**crime scene**)
- Identify how existing standards & guidelines were adapted (**to solve the crimes**)
- To share the lessons learned during the development of a home care surveillance strategy (**CSI approach**)



VON Canada

- **51 Branches across Canada**
- **6,000 staff**
- **12,000 volunteers**
- **Services:**
 - Visiting Nursing (clinics, shift)
 - Home Support
 - Community Support



Home Care: The IP&C Challenges (Crimes) ??? Crime Scene??

- Changing infection risks in home care
- Funders & accreditors require infection monitoring
- IP&C standards & guidelines—more suited to institutional care



Investigative Unit: Team VON

- National Director, Quality and Risk
- National Director, Clinical Services
- National Practice Consultant
- IP&C Committee (local experts and eager assistants)



Accreditation Canada (AC) IP&C Standard 1

- **Required Organizational Practices:** the organization tracks infection rates, does analysis & shares information throughout the organization.
- **Test(s) for Compliance**
 - 1.2.1 Infection rates are monitored.
 - 1.2.2 Staff know the relevant infection rates.



Accreditation IP&C Standard 1

Problematic Indicators

1.3 Indicator: Surgical Site Infection.

- The organization tracks surgical site infections.

1.4 Indicator: Health Service Associated (Nosocomial) Infection.

- The organization tracks one health care associated infections: MRSA and/or C.difficile.

1.5 The organization uses standard definitions and accepted statistical techniques

- So information can be shared and compared.



The Search for Evidence

To ensure our approach was evidence-based:

- Published evidence
- Consulted with leading IP&C experts in Canada (PHAC, CHICA, RICN)



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Grissom always says... follow the evidence

WHY and HOW...

- Targeted approach
- Obtain a baseline infection rate – then identify ongoing trends
- Relevant to home care:
 - Invasive medical devices & invasive care
 - Related to processes of care
 - Monitor infections that we have control over



Home Care Standardized Definitions

2008 APIC -HICPAC home care definitions

- **Based on clinical presentation**
- **Infection sites (BSI, wounds) not bugs (VRE, MRSA, C. Diff)**
- **Home-care associated infections (> 48 hours)**
- **Infection/not colonized**
- **Actionable data** – collect data about something we can influence



Narrowing the Investigation

- **Non-surgical wound infections**
 - Almost 40% clients visited require wound care
 - Wound care is invasive
 - Able to make practice changes to wound care



Investigation into HOW?

- **Phased Approach:**
 - Local pilot 1st with small group
 - Rollout – incorporate lessons learned from pilot
- **To Learn:**
 - HOW do we engage autonomous, mobile workers to report infections?
 - HOW do we get the data from staff to a centralized database?
 - Will we get meaningful, actionable data?



Local Investigation

- **Learn how to:**
 - Collect data to assess wound care
 - Use the “right” reporting tool
 - Implement reporting process with mobile workforce
- **Partnered with North Simcoe Muskoka RICN:**
 - Small Projects for IP&C and Quality Assurance Grant
 - Access to IP&C expertise, data analysis



Documenting the Evidence

Non-Surgical Wound Infection Reporting Tool

- Based on APIC-HICPAC home care definitions
- Narrowed definition to focus on non-surgical wound infections
- Simplify tool “KIS” – *so we can catch the culprit!*



Processing The Evidence

Standardized Process

- **Use current processes**
 - Paper based tool
 - Fax to central location
- **Efficiency -least # of steps**
- **Data entry by clerical staff**





Training the Investigators

- Who: all RNs & RPNs providing wound care
- How?
 - Tutorial & in-class education
 - Quick reference fact sheet
 - Mock reporting tool
 - Case study & tool completion
 - Reflective practice form
- Evaluation



Barriers to Evidence Collection (Reporting)

Infections not reported because:

- **Time constraints**
- **Lack of confidence**
- **Fear of blame**
- **Lack of feedback**
- **Perceived lack of value in the reporting process**



What did our investigation reveal?

- **Evidence Based Practice** - do the research and let the evidence speak...leading practices
- **Capture Quantitative Data:** # infections, wound types & locations, underlying risk factors
- **Tool:** simplify to engage staff; consult with experts to create tools
- **Reporting Process:** use familiar processes... faxing, reporting to central location...few steps & people



What did our investigation reveal? cont'd

- **Tutorial vs In-Class Education:**
 - Lots of technology glitches
 - Offers learning choices & scheduling flexibility
 - Reduce direct costs
- **Communication:**
 - Key to engaging folks



National CSI Approach (Surveillance)

- **Incorporate Lessons Learned**
 - Target non-surgical wound infections
 - Use national Event Reporting System to collect data
 - Communication
 - Education – tutorial & in-class

Infection Surveillance...ongoing investigation



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Next Steps – Answer What & Who

- WHAT do we analyze?
- WHAT do with the data we are collecting?
- WHAT info does everyone need?
- WHO do we share the information with?
- WHAT will we do to improve practices?



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