

Leading the Way
to Better Healthcare

**Surveillance Strategies for Success Part 2:
Using the TAP Strategy**
March 11, 2016

Partners for Better Healthcare







Today's Speakers



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Healthcare-Associated Infections
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Objectives


Goals today:

- Understand Targeted Assessment for Prevention (TAP) process
- Discuss how to run TAP reports and interpret the data
- Review CAUTI TAP assessment
- Share CAUTI TAP resources
- Learn from hospitals' perspectives about using the TAP strategy





NHSN Data for Action



NHSN data; over 4,800 hospitals currently reporting CAUTI, CLABSI, and CDI data



Target hospitals with high number of excess infections





Partner for prevention with quality improvement networks-quality improvement organizations, hospital engagement networks, health departments

Targeted Assessment for Prevention (TAP) Strategy



Target → Assess → Prevent

- Target facilities/units with high burden/excess of HAIs
- Assess gaps in infection prevention in targeted facilities/units
- Prevent infections by implementing interventions to address the gaps

Benefits of TAP Strategy

- Focused approach to prevention
- Within targeted facilities, excess HAIs mapped to unit level
- Cumulative attributable difference (CAD) is a concrete prevention goal linked to the standardized infection ratio
- Specific gaps in infection prevention identified through a standardized assessment of targeted units
- Implementation strategies customized to address gaps

TARGET
NHSN TAP Reports

ASSESS

PREVENT

TAP Reports bring together data elements from other reports within NHSN:

- Annual Survey
- Rate Tables
- SIRs
- Event-level information (CLABSI, CAUTI, and CDI only)

Facility Type	CLABSI	CAUTI	CDI LabID
Acute Care Hospital	✓	✓	✓
Long Term Acute Care Hospital	✓	✓	
Inpatient Rehab Facility		✓	






Cumulative Attributable Difference (CAD)

= # OBSERVED infections – (# PREDICTED infections * SIR_{goal})

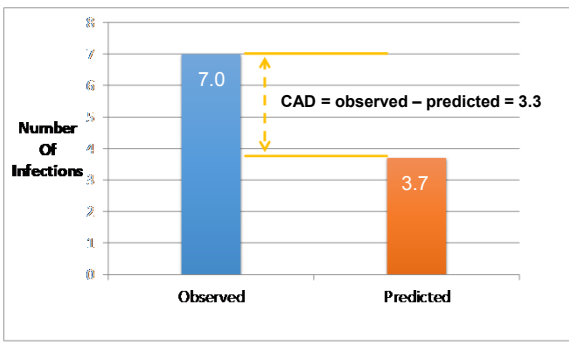
Standardized infection ratio (SIR)_{goal} can be chosen based on goals of a group, state, organization, or national target

- Lower target SIR → larger CAD (“excess” number of infections)
- NHSN uses HHS target SIRs with option to customize

CAD is the number of infections needed to prevent to reach the SIR_{goal}

Cumulative Attributable Difference (CAD) SIR goal = 1.0



Standardized Infection Ratio (SIR)

- a. The SIR is a measure that compares the number of HAIs reported to NHSN to the number of infections that would be predicted based on national baseline data:

$$\text{SIR} = \frac{\text{Observed \# of HAIs}}{\text{Predicted \# of HAIs}}$$

- b. SIR Interpretation:

- 1: same number of infections reported as would be predicted given the US baseline data
- >1: more infections reported than what would be predicted given the US baseline data
- <1: fewer infections reported than what would be predicted given the US baseline data

CAD vs. SIR

Metric	Calculation	Purpose	Limitations
CAD	Observed – (Predicted* SIR_{goal})	<i>Prioritization</i> metric. Identifies facilities and units w/ the highest burden of excess infections.	Influenced by exposure size (i.e., a larger hospital w/ many patient days will likely have a higher CAD than a small hospital).
SIR	$\frac{Observed}{Predicted}$	<i>Comparative</i> metric. Summary measure used to track HAIs over time. Adjusts for differences among risk exposure categories.	SIRs not calculated in NHSN if <1 predicted infections.

Hospital Type	Catheter Days	Observed Events	Predicted Events	SIR_{goal}	Predicted * SIR_{goal}	SIR	CAD
Major Teaching	9,000	36	12	0.5	6	3	30
Rural Hospital	1,497	6	2	0.5	1	3	12

Running TAP Reports

Expand All **Collapse All**

- Device Associated (DA) Module
- Procedure Associated (PA) Module
- HAI Antimicrobial Resistance (DA+PA Modules)
- MDRO/CDI Module - Infection Surveillance
- MDRO/CDI Module - LABID Event Reporting
- MDRO/CDI Module - Process Measures
- MDRO/CDI Module - Outcome Measures
- Antimicrobial Use and Resistance Module
- CMS Reports
- TAP Reports
 - Single Care Reportable (ACRs)
 - Display Infection Count
 - TAP Report - CLAB data for ACRs Run Modify
 - TAP Report - CAU data for ACRs Run Modify
 - TAP Report - Facilitywide CDI LabID data for ACRs Run Modify
 - Long Term Acute Care Reportable (LTACs)
 - Display Infection Count
 - TAP Report - CAU data for LTACs Run Modify
 - Long Term Acute Care Reportable (LTACs)
 - Display Infection Count
 - TAP Report - CLAB data for LTACs Run Modify
 - TAP Report - CAU data for LTACs Run Modify
- Advanced
- My Custom Output
- Published Output

CLABSI
CAUTI
CDI

Running TAP Reports

Choose TAP Report from CDC Defined Output from healthcare setting of interest

- a. Run – Default TAP Report
- b. Modify – Customized Report.
 - a. Time period of Interest
 - b. Cumulative Attributable Difference (CAD) Multiplier

Running TAP Reports

Generate a report for a time period (the larger the better)

Select a time period or Leave Blank for Cumulative Time Period: [Help](#)

Date Variable

Beginning

Ending

Clear Time Period

☐ Enter Date variable/Time period at the time you click the Run button

↓

Select a time period or Leave Blank for Cumulative Time Period: [Help](#)

Date Variable

Beginning

Ending

Clear Time Period

☐ Enter Date variable/Time period at the time you click the Run button

Running TAP Reports

Select a time period or Leave Blank for Cumulative Time Period: [Help](#)

Date Variable: Beginning Ending

☐ Enter Date variable/Time period at the time you click the Run button

Specify Other Selection Criteria: [Help](#)

Show Columns Columns to Run: Clear Column

Other Options: [Show Variable Reference List](#)

Cumulative Attributable Difference (CAD) Multiplier



Source: HHS Goal

CAD Multiplier

Default NHSN goals are based on HHS 5-year HAI Reduction targets

- CAUTI SIR_{goal}: 075
- CDI SIR_{goal}: 0.70
- CLABSI SIR_{goal}: 0.50

HHS goals: <http://health.gov/hcq/prevent-hai-measures.asp>

Helpful Hints for Running TAP Reports

Default output format is HTML



- If another format, (e.g., RTF) is selected, change the orientation to "Landscape"

Use of variable labels will provide more descriptive column headers

Select output format:

Output Format:

☒ Use Variable Labels

[illegible]

Interpreting TAP Report Results

National Healthcare Safety Network
TAP Report - CAUTI Data for Acute Care Hospitals
Locations Ranked by CAD Within a Facility
Cumulative Attributable Difference (CAD) Multiplier: HHS Goal = 0.75
as of February 28, 2016 at 10:00 AM
Data Range: CAUTI_TAP summary by device to 2016

FACILITY				LOCATION							
orgID	name	locCAD	locRank	location	locCode	locCount	numObsDays	locDUR	locCAD	locSIR	numPatDays
17028	State of VA Medical Center	0.81	1	ICU	ICU	1	24	12	0.25		1 (1, 0, 0, 0, 0)
		2.20	2	ICU	ICU	2	100	20	0.80		

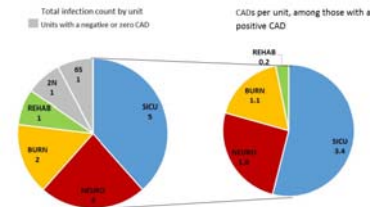
The Facility CAD indicates how many infections this hospital would have had to prevent to reach its goal.

The CAD for each location indicates how many infections that particular unit would have had to prevent to reach its goal.

Suggestion to round this number UP when explaining the data to others.

Communicating TAP Report Results: Example

Graphical representation of unit level TAP Report; Distribution of DHQP Memorial 2014 CAUTI counts total by unit (for units with at least 1 observed infection) and for units with a positive CAD* based on an SIR target of 0.75.



* Cumulative Attributable Difference - The number of infections each unit would have needed to prevent to achieve the facility-wide national SIR goal of 0.75 during 2014.
CAD = Number of observed events (Number of predicted events * SIR goal)

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VDH Communicating TAP Report Results: DRAFT

Facility Specific Healthcare-Associated Infection (HAI) Prevention Progress Report, Virginia, 2016Q1 (1/1/16-3/31/16)

Legend:

Red text means significantly more infections than predicted, based on the national baseline
Green text means significantly fewer infections than predicted, based on the national baseline
Yellow highlight means this facility is among the top 5 hospitals with the highest number of infections needed to be prevented to reach the SIR goal
* Number of infections needed to prevent to reach SIR goal (cumulative attributable difference) = (predicted infections * SIR goal)

		Facility Standardized Infection Ratio (SIR) and 95% Confidence Interval (CI)				Facility Name: Hospital A				Statewide Comparison	
HAI	Type/Unit	SIR	CI	SIR Goal*	Observed Infections	Excess Infections** (If Needed to Prevent to Reach SIR Goal)	Among the Top 5 VA Hospitals with the Highest Number of Excess Infections?	VA SIR (2016Q1)			
CAUTI	Adult/pediatric ICUs	1.41	(1.04, 1.87)	0.75	45	13	YES	XXX			
	Adult/pediatric wards	0.82	(0.57, 1.14)	0.75	32	12	YES	XXX			
CLABSI	Adult/pediatric ICUs	0.57	(0.31, 0.94)	0.50	13	-	NO	XXX			
	Adult/pediatric wards	0.67	(0.21, 1.63)	0.50	4	1	NO	XXX			
LabSI	ICU	0.33	(0.11, 0.85)	0.50	4	-	NO	XXX			
	CDI	1.56	(0.89, 2.55)	0.70	14	5	YES	XXX			
SSI	MRSA	2.29	(1.59, 3.19)	0.75	32	18	YES	XXX			
	CSSD	1.29	(0.65, 2.58)	0.75	9	2	NO	XXX			
	HYST	1.00	(0.05, 4.93)	0.75	1	-	NO	XXX			

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Polling Question

When you ran your 2015 CAUTI TAP report, were the results what you expected?

- a. Yes
- b. No; the report highlighted excess infections in units that I did not anticipate
- c. I did not have the opportunity to run the TAP report

Hospital Perspective



Jill E. Holdsworth, MS, CIC, NREMT
Infection Control Practitioner,
Sentara Northern Virginia Medical Center

Targeted Assessment for Prevention (TAP) Strategy

Target → Assess → Prevent

- a. TARGET
- b. Assess gaps in infection prevention in targeted facilities/units
- c. Prevent infections by implementing interventions to address the gaps

The CAUTI Initial Assessment

- a. A large portion of the TAP strategy is to perform a baseline assessment of staff knowledge in hospital CAUTI prevention programs before instituting new protocols and education.
- b. This assessment is designed to capture your hospital's current state as it relates to CAUTI prevention.



The CAUTI Initial Assessment

- a. This initial assessment tool may be used to determine potential gaps in infection prevention in facilities with excess numbers of CAUTIs (positive CAD).
- b. This tool may also be used to validate effectiveness of new education and/or practice.
- c. Sustain the gain!



The CAUTI Initial Assessment

- a. This assessment can be administered hospital-wide to gain knowledge of all areas and staff.
- b. Perform assessment on a single unit if you have an outlying unit with high CAD.
- c. Use assessment after participating in a program such as CUSP to validate effectiveness of the program.



The CAUTI Initial Assessment

All staff levels needed for accurate results

- Physicians
- Leadership
- Staff nurses, and unit managers
- Nursing assistants
- And others, that have access to patients with indwelling urinary catheters
- Include staff from ALL shifts

[illegible]

The CAUTI Initial Assessment

Options for distributing the assessment

- a. **SURVEY MONKEY** (most popular)
- b. **Electronically:** The PDF is set up to be emailed to VHQC once the submit button has been selected. (Check Firewall)
- c. **Hard copy (paper):** The designated project Point of Contact (POC) can print the assessment, and hand it out to staff who will return it to the hospital POC. (VHQC will pick up or provide postage for surveys)



Electronic or Paper Submission

[illegible]

Electronic or Paper Submission

1. General Infrastructure, Capacity, and Processes	Response	Comments (and/or "As Evidenced By")
1. Is senior leadership involved in CAUTI prevention activities?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> N/A	
2. Is unit level leadership involved in CAUTI prevention activities?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> N/A	
3. Does your facility currently have a team/work group focusing on CAUTI prevention?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> N/A	
4. Does your facility have a staff person with dedicated time to coordinate CAUTI prevention activities?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> N/A	
5. Does your facility have a nurse champion for CAUTI prevention activities?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> N/A	
6. Does your facility have a physician champion for CAUTI prevention activities?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> N/A	
Does your facility train staff on:		
7. Aseptic technique for urinary catheter insertion (for all staff who are given responsibility for inserting indwelling urinary catheters)?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> N/A	
8. Proper urinary catheter maintenance procedures (for all staff who are given responsibility for indwelling urinary catheter care)?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> N/A	
9. Use of bladder ultrasound scanners (for all staff who use them)?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> N/A	
10. Proper indwelling urinary catheter handling and placement of the drainage bag (for all staff involved in moving patients including transport personnel)?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> N/A	
11. Appropriate indications for urine culturing (for entering services)?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> N/A	
Does your facility conduct periodic assessments * of:		
12. All staff who insert indwelling urinary catheters to ensure proper aseptic technique: A. Upon hire/during orientation? B. At least annually?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> N/A <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> N/A	

* Periodic assessments is defined as a process of ensuring that healthcare personnel demonstrate the use of knowledge to perform a practice correctly and according to facility standards and policies. This may be done through direct observation by hospital or department of personnel performing a procedure, simulation or a combination of our listed practices or policies.



Electronic or Paper Submission

13. Presenting Candidates and Detection of Appropriateness	Response Choices						Comments (and/or "As Evidenced By")
	Never	Rarely	Sometimes	Often	Always	Not Applicable	
1. Do providers document in the medical record at least once during entry a date, duration, and indication for all uncomplicated catheters at your facility?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
2. Does your facility have a leader (e.g., physician, pharmacist) who is responsible for antimicrobial stewardship activities?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
3. Do entering providers send urine cultures on asymptomatic patients at your facility?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
4. Are urine culture specimens requested for the lab for testing immediately following insertion at your facility (i.e., not allowed to sit unrefrigerated for prolonged periods of time)?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	

Additional Comments/Observations (Please specify/Describe in detail):

Submit

**If unable to Submit, please Print

Print

Clear Responses

Please Email Us Only: Survey Shadow



Survey Monkey Assessment

The **CAUTI Initial Assessment** (provided in SurveyMonkey format) is designed to capture your hospital's current state as it relates to CAUTI prevention.

- a. It's imperative that we receive responses from a variety of staff at all levels in your hospital. Please **distribute** the link for the assessment to:

- Staff and managers in all units where indwelling urinary catheters are used (even if CAUTIs have not been a problem)
- Infection prevention leaders and staff
- Quality improvement leaders and staff
- Senior leaders
- Providers

The more people in your hospital who complete the assessment, the better we will be able to identify areas of need to focus improvement efforts.

- b. Please provide everyone completing the assessment with the following advice:

- Your hospital **CCN #**
- The assessment will take about 15 minutes to complete and must be completed in its entirety at one sitting. If it's necessary to stop while doing the assessment, start over at a later time.
- Your answers should be in response to current practices and reflect the first thought(s) that come to mind.
- If you do not know the answer mark it as unknown – do not look it up!
- Responses are anonymous.
- Please complete the assessment tool using the following link by **XXXXX**.

<https://www.surveymonkey.com/s/295v820>

- c. Incomplete assessments will be excluded from analysis.



Survey Monkey Assessment

CAUTI - Initial Facility Assessment Tool 2015 - 2016


Instructions

This initial assessment tool may be used to determine potential gaps in infection prevention in targeted facilities with excess numbers of CAUTIs.

This assessment may be done at the facility and/or unit-specific level depending on where the data indicate excess CAUTI events and/or excess urinary catheter utilization.

Notes:

- Responses should refer to what is currently in place at the facility/unit (i.e., at the time of the visit/communication).
- For Section I, the respondent should provide categorical "Yes/No" responses whenever possible. Responses indicating "Unknown" should be accompanied by a comment describing the reason. For Sections II-VI, a response scale of "Never, Rarely, Sometimes, Often, and Always" should be used. If an item is "Not applicable", please specify in comment boxes as appropriate.
- Please also use the comment boxes to elaborate and capture information as needed - such detailed comments may help focus additional drill-down opportunities and next steps. Please also feel free to request additional supporting materials (e.g., policy or procedure manuals, review of medical records) when and where possible.



Survey Monkey Assessment

1. Facility Name:

2. Date of Assessment:

Date/Time MM DD YYYY

3. Facility CCN:

4. Unit ID/Description (if unit-specific assessment):

5. Unit Type:


☐ ICU

☐ ED

☐ INWARD

☐ OTHER

☐ NA



Survey Monkey Assessment

6. Title or Role of person interviewed (if more than one role, please indicate here):

Title/Role #1

Title/Role #2

7. Title or Role of person interviewed

Other (please specify)

7. Title or Role of person interviewed

Nurse

Nurse Manager / Supervisor

Certified Nurse Assistant

Nurse practitioner

Physician - Attending

Physician - Resident/Fellow


Physician Assistant

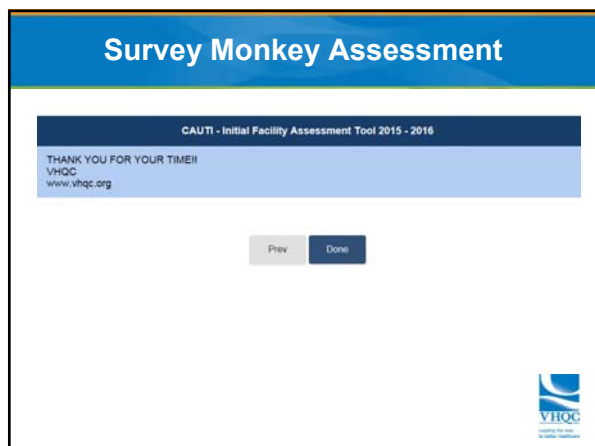
Administrative Leadership - Nurse

Administrative Leadership - Physician

Administrative Leadership - Other


Infection Preventionist






Instructions for Staff

- a. Your hospital **CCN #**
- b. The survey will take about 15 minutes to complete and must be completed in its entirety at one sitting. If it's necessary to stop while doing the survey, start over at a later time.
- c. Your answers should be in response to current practices and reflect the first thought(s) that come to mind.
- d. If you do not know the answer, mark it as unknown – **do not look it up!**
- e. Responses are anonymous.



Assessment Completion

- a. Once the completed assessment tools are collected, VHQC will aggregate the responses and provide a feedback report to your hospital leaders and teams.
- b. The feedback report will identify knowledge and practice gaps by staff level.
- c. Targeted education and process improvement actions can then be planned and implemented.
- d. If you have recently experienced decrease in CAUTI events and a lower SIR; the tool can be used to validate successful education and /or process improvement efforts.



Preparing Feedback Report

Filter Applied?	Yes
Overall Number of Assessments in Database:	Number Presented in Summary Report:
0	0

Assessment results are entered into an Excel database and summarized to get an overall score and identify domains and areas for improvement.

Average Summary Scores

Total Score (Range 0-100)	80/100/101
Section 1 Score (Range 0-100)	80/100/101
Section 2-6 Score (Range 0-100)	80/100/101

By Facility Staff

1. Is your Leadership involved in CAUTI prevention activities?	2. Does your Facility have a staff training program for CAUTI prevention activities?	3. Does your Facility have a nurse champion for CAUTI prevention activities?	4. Does your Facility have a physician champion for CAUTI prevention activities?
Yes	Yes	Yes	Yes
No	No	No	No
Unknown	Unknown	Unknown	Unknown


Results: Summary Scores

Section 1: General Infrastructure, Capacity, and Processes

- Dichotomous yes/no questions
- Possible Score of 25 (1 point for each yes)

Questions 1 – 25

- Engagement of Leadership, Champions, and Staff
- Staff Training and Competency Assessments
- Routine Audits: Insertion protocol, nurse driven protocol
- Feedback



Results: Summary Scores


Section 2: Appropriate Indications for Indwelling Urinary Catheter Insertion
Score 10

Section 3: Aseptic Insertion of Indwelling Urinary Catheter
Score 4

Section 4: Proper Indwelling Urinary Catheter Maintenance
Score 3

Section 5: Timely Removal of Indwelling Catheter
Score 11

Section 6: Preventing Candiduria and Detecting Asymptomatic Bacteriuria
Score 4



Results: Summary Scores

- a. Section 2 – 6 possible score of 32
- b. Combined for a sub score scaled to 1 point
 - a. 1 point for Always
 - b. 0.75 for Often
 - c. 0.5 for Sometimes
 - d. 0.25 for Rarely
 - e. 0 for Never



Implementation Example

5. Does your facility have a nurse champion for CAUTI prevention activities?	6. Does your facility have a physician champion for CAUTI prevention activities?
# of Responses per Question	
41	41
Yes:	
49%	15%
No:	
30%	30%
Unknown:	
21%	49%

- Section 1: General Infrastructure
- Only 15% responded that the facility has a physician champion
- Use the CDC CAUTI Toolkit for links to physician engagement.



Targeted Assessment for Prevention (TAP) Strategy

Target → Assess → Prevent

- a. TARGET
- b. ASSESS
- c. Prevent infections by implementing interventions to address the gaps



The CAUTI Toolkit Implementation Guide

<http://www.cdc.gov/hai/prevent/tap/resources.html>

General Infrastructure, Capacity, and Processes

Engagement of Leadership, Champions, and Staff

Engage the Senior Executive Module - Comprehensive Unit-based Safety Program (CUSP) Toolkit

Curriculum focused on the role and responsibilities of senior executives, from the Agency for Healthcare Research and Quality (AHRQ)

CAUTI Cost Calculator

Tool to engage leadership that estimates facility costs due to CAUTI, from catheterout.org

Implementation Team Roles and Responsibilities

Summary of recommended personnel to engage for CAUTI reduction efforts, from catheterout.org

CUSP Board Checklist

Checklist of activities to involve for senior leadership in the prevention of patient harm, from the Agency for Healthcare Research and Quality

CDC Safe Healthcare Blog - Why So Many Foleys?

Discussion of best practices for managing urinary catheters and reducing risk of CAUTI, guest author Wendy Kahler, MPH, CIC, Dignity Health

Strategies and Tips for Nurse Engagement

Strategies to engage nurses as champions in CAUTI prevention, from catheterout.org

Strategies and Tips for Physician Engagement

Strategies to engage physicians as champions in CAUTI prevention, from catheterout.org

Presentation to Nurse Manager & Case Manager (or Unit Champion)

Agenda for presentation to unit champion, from the Agency for Healthcare Research and Quality, CUSP Toolkit

Implementation Resources

Downloaded at
www.catheterout.org

Strategies for Physician Engagement

- Involve physicians as much as possible in planning, education, and implementation, include physicians (e.g., hospitalists, urologists, hospital epidemiologists, and infectious disease physicians) on your team.
- Gain support of medical leadership, e.g., chief of staff, chief medical officer.
- Have the physician champion meet with physicians to get them on board.
- Conduct education on, for example, CMS rule changes, proper indications, evidence supporting reducing catheter use, evidence that physicians are often not aware that a patient has a catheter.
 - Education can be conducted through, for example, presentation in staff meetings by the physician champion and nurse managers, CME's, one-on-one, and through printed and electronic materials such as pocket cards, flyers, or a newsletter. See section "Flyers and pocket cards" at <http://catheterout.org/tap-flyers-and-pocket-cards>.
- Periodically post catheter prevalence and CAUTI rates in a physician venue.
- If you are part of a large health care system, influence and leverage system policies on physician practices.
- Physicians-in-training, physician assistants, and nurse practitioners may also play a key role in catheter-associated urinary tract infection-related activities, depending on the hospital and the unit, thus the above strategies may also apply to these important care providers.



CAUTI Prevention Action Plan

Area of Focus	Action Steps	Person(s) Responsible	Completion Date
Competency Assessment for use of Bladder Scans			
Ordering providers use indwelling urinary catheters for appropriate indications			
Indwelling catheters removed in PACU			




Resources


TAP Implementation Toolkit:
<http://www.cdc.gov/hai/prevent/tap/resources.html>

FAQs: <http://www.cdc.gov/hai/prevent/tap.htm>


TAP Report Quick Reference Guide for Facilities:
http://www.cdc.gov/nhsn/PDFs/TAP/TAPReports_Facilities.pdf



Provider Experience with TAP




Denise Marsh, BSN, RN, CIC
Infection Prevention and Control Coordinator
Western Maryland Health System



CAUTI TAP Assessment

WMHS January 2016



Onboarding call with VHQC

- December 2, 2015-
 - Nursing Directors
 - Nurse Managers
 - Charge nurses
 - CAUTI Team Members (includes RN, LPN and Nursing assistants)
 - Infection Prevention and Control
 - PI
 - Education

When to roll out tool

- Decided to wait until after the holidays
- Survey 1/4/16 -1/15/16
- December 31st
 - Sent the link to Survey monkey and instructions via email to the NM of all of the inpatient units along with the ED NM sent this info to their respective staff

Survey Period

- Reminder emails sent throughout the 2 week period this included the instructions and survey link
- IP contacted hospitalist group –they filled out on paper and slid under our office doors
- IP contacted urology group–they entered into survey monkey

Follow up Survey Results

- Site Visit with VHQC consultant 2/24/16
 - Nurse Managers, PI and Education attended
 - Excellent feedback from audit results
 - Action Plans from consultant to get us headed in the right direction

Questions?



This material was prepared by VHQC, the Medicare Quality Innovation Network Quality Improvement Organization for Maryland and Virginia, under contract with the Centers for Medicare & Medicaid Services (CMS), an agency of the U.S. Department of Health and Human Services. The contents presented do not necessarily reflect CMS policy. VHQC1152080360201604-00



VHQC Online Community

Join the VHQC online community by visiting
www.vhqc-qinqio.ning.com




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 Contact for HAI data/reports & National Healthcare Safety
 Network technical assistance

Carol Jamerson, BSN, RN, CIC – Nurse Epidemiologist
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 Contact for consultation on infection prevention-related issues


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 Contact for data requests, educational materials



VHQC Contact Information

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 NHSN technical assistance for MVHIN providers

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Save the Date!

Surveillance Strategies for Success Part 3:
 Annual NHSN Training Updates
 Friday, April 8
 12:00 PM – 1:00 PM

