HealthInsight Regional HAI Reduction Summit

Part 1—*Clostridium difficile* Prevention: Coming Together to Examine What Works

March 23, 2016

Questions and Answers from the Summit

Recordings from the Summit are available on the HealthInsight YouTube channel:
https://www.youtube.com/channel/UCQCuGMyHlpGski_mqWNAn3w

Section 1: Rochelle Neilson

1. **On patients that have had a history of C-diff, is documentation of 3 negative stool samples required to avoid C-diff precautions on each subsequent admissions, even if asymptomatic?**
   Saint Mary's Regional Medical Center's protocol requires looking for symptom onset rather than relying on lab results from stool samples. This is to avoid implicating people with a history as necessarily being a transmission risk unless there is symptomology.

   NOTE: Rochelle is interested in hearing more about protocols with stool samples and would be happy to go over this with anyone interested. You can contact her at RNeilson@primehealthcare.com.

2. **How many people are staffed in the Infection Prevention department at Saint Mary's Regional Medical Center?**
   2 FTEs for the average census of 170–200+

3. **Do you have any data pre and post interventions?**
   Yes, we saw a 70% reduction in January. Data shows a significant decrease in Hospital Supply Organism (HSO) rates since protocols were instituted.

4. **Is starting acidophilus with treatment shown to be effective?**
   There is currently no scientific evidence seen by pharmacists that can support the use of probiotics to help with C-diff disease. However, this is an ongoing study as more and more people are suggesting that probiotics may be helpful.

5. **What is PCR Testing?**
   Polymerase chain reaction (PCR) is a sensitive molecular test that can rapidly detect the C. difficile toxin B gene in a stool sample and is highly accurate. It will always determine the presence of C-diff but it doesn't always help determine if the patient has active disease. May identify cases that are colonized rather than truly active C-diff cases. Here is a link to a website that has more information about PCR testing:
   http://www.medicinenet.com/pcr_polymerase_chain_reaction/article.htm

6. **Is the PCR test run in the first 1-3 days? How often should they be performed after that?**
   Patients are tested at admission, even without symptoms. Antigen-positive toxin-negative patients are automatically done within the first 3 days. Testing is not recommended for negative patients within the first 7 days and if the patient is symptomatic again. PCR testing and antigen testing are not something that are done routinely or continually, it is just a one-time thing.

Part 2: Genevieve Buser

7. **What is the website for the Oregon resources just mentioned?**
   Oregon IFT webpage:
   https://public.health.oregon.gov/DiseasesConditions/CommunicableDisease/HAI/Prevention/Pages/Interfacility-Communication.aspx

8. **Should Long Term Care (LTC) be doing C-diff screening?**
   Not generally recommended unless if you have a facility with a very high onset incidence as with 2 units, it may be worthwhile doing that for a defined period to understand what is coming in the door. There will need to be clear outcomes of how you are going to use that data (i.e. target a specific intervention, get a sense of what burden's come through the door, change environmental cleaning or contact precautions, etc.).

   Hospitals face a similar issue as LTC facilities with not knowing what it means to be an asymptomatic carrier of C-diff. Treating patients with C-diff may actually provoke symptomatic diarrhea. For example, working on a project with a hospital looking at prevalence to get an idea of the burden that is coming in but will not lead to further treatment of asymptomatic patients. Instead, we will identify and follow them over time to see which percentage do become symptomatic or if there are events of transmission that are linked to them, if possible.

9. **Should a patient who is colonized but not symptomatic be treated?**
   No! If someone is just colonized and they are not having symptoms but you treat them with Flagyl, you may in fact provoke them having a symptomatic C-diff colitis. Currently, there is no recommendation to treat for only a colonized patient.

Part 3: Whitney Buckel

10. **What are some of the ways that communities are looking at antimicrobial stewardship, aside from hospital programs?**
    There has been a push to do antimicrobial stewardship in long-term care facilities and in the outpatient settings. Studies show there is definitely a need and they are looking in those areas. This is very new so they are still in the process of learning how to conduct antimicrobial stewardship in those settings. Pillars will need to be conducted such as coming up with protocols and education initiatives. However, education will be hard to maintain if there is some particular staff turnover.

11. How did physicians receive the feedback audit process and limitations on the formulary?

Before the 15 month intervention phase was conducted, there was the 6 month education program. The prep work leading up to it along with trying to get buy in were really important factors. Site visits were conducted at 15 different hospitals to meet with providers and explain the rationale. Clarified that many of these restrictions were not due to poor performance, rather they looked back at the microbiology of looking at the antibiogram, stratifying risk, clarifying that the formulary does not need to be used in all situations.

Part 4: Susan Kellie

12. Is there any data showing the result of using UV-bot cleaning status post hygienic/terminal cleaning?

Yes! The manufactures will show experimental data confirming that this machine does kill C-diff. You have to pull the machine around different areas of the room, both sides of the bed, when it is a direct line of sight UV. In order to make this work, staff will have to have to appropriate training, use, and communication.

13. What does "hygienic cleaning" entail?

Hygienic cleaning is the new terminology for a higher level of cleaning. It acknowledges that the area is being cleaned much more than what we can see with the naked eye. It involves cleaning bacterial spores and significantly reduces bio burden (i.e., "crud" that may be dead or alive). Reducing invisible crud otherwise can only be measured with techniques like using ATP; a machine that measures biologic crud on surfaces.

14. Is it best practice to use a sporicidal disinfectant for cleaning of ALL clinical areas? Or is it acceptable to only use for identified patients and then use a different EPA disinfectant for all other areas?

It is absolutely acceptable to limit your sporicidal disinfectants to individual patient rooms where you have identified a C-diff patient. Reasons for this:

- The sporicidal disinfectants are difficult to use everywhere because nursing staff, patients, or cleaning staff may object to the bleach odor, especially in areas that have multi-vented rooms.
- Skin can become irritated if using bleach on a more regular basis.
- Bleach can be hard on vinyl and stainless steel

Consider expanding the use of sporicidal cleaning in areas where rate in C-diff cases continue to increase, possibly due to a high number of colonized rooms.

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