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From Data to Discovery: Interpreting Data for Action

Presented by the Healthcare Safety Group

Learning Objectives



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Participants will be able to:

- Discuss results of the Infection Control Assessment and Response (ICAR) project in Texas.
- Describe how the National Healthcare Safety Network's (NHSN) new baseline may affect their healthcare associated infection data reports.
- Understand how the use of Targeted Assessment for Prevention (TAP) Strategy for NHSN data can help to identify, assess and target prevention efforts.

Data, data, data



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“In God we trust. All others must bring data.”

“We spend a lot of time getting data, but not looking at it.”

“The goal is to turn data into information, and information into insight.”

“Some of the best theorizing comes after collecting data because then you become aware of another reality.”

“Things get done only if the data we gather can inform and inspire those in a position to make [a] difference.”



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ICAR visits

Susana Baumann, MPH, CIC

Gretchen Rodriguez, MPH, CIC

What are ICAR Visits?

- CDC-sponsored program to support state-driven efforts on improving infection prevention and control capacity
- Goal – assist facilities with infection control program
- Facility selection – collaborative, voluntary



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Data Collection Tool



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II. Infection Control Training, Competency, and Implementation of Policies and Procedures		
Elements to be assessed	Assessment	Notes/Areas for Improvement
A. Hand Hygiene		
<p>1. Hospital has a competency-based training program for hand hygiene.</p> <p>Verify the following:</p> <ul style="list-style-type: none"> a. Training is provided to all healthcare personnel, including all ancillary personnel not directly involved in patient care but potentially exposed to infectious agents (e.g., food tray handlers, housekeeping, and volunteer personnel). b. Training is provided upon hire, prior to provision of care at this hospital. c. Training is provided at least annually. d. Personnel are required to demonstrate competency with hand hygiene following each training. e. Hospital maintains current documentation of hand hygiene competency for all personnel. 	<p><input type="radio"/> Yes <input type="radio"/> No</p> <ul style="list-style-type: none"> a. <input type="radio"/> Yes <input type="radio"/> No b. <input type="radio"/> Yes <input type="radio"/> No c. <input type="radio"/> Yes <input type="radio"/> No d. <input type="radio"/> Yes <input type="radio"/> No e. <input type="radio"/> Yes <input type="radio"/> No 	
<p>2. Hospital routinely audits (monitors and documents) adherence to hand hygiene.</p> <p>Verify the following:</p> <ul style="list-style-type: none"> a. Respondent can describe process used for audits. b. Respondent can describe frequency of audits. c. Respondent can describe process for improvement when non-adherence is observed. 	<p><input type="radio"/> Yes <input type="radio"/> No</p> <ul style="list-style-type: none"> a. <input type="radio"/> Yes <input type="radio"/> No b. <input type="radio"/> Yes <input type="radio"/> No c. <input type="radio"/> Yes <input type="radio"/> No 	

Additional Areas



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- Kitchen
- Laundry
- Medication rooms
- Additional patient centered rooms
- Miscellaneous items & services
(e.g., fountains, pets,
disinfectants)



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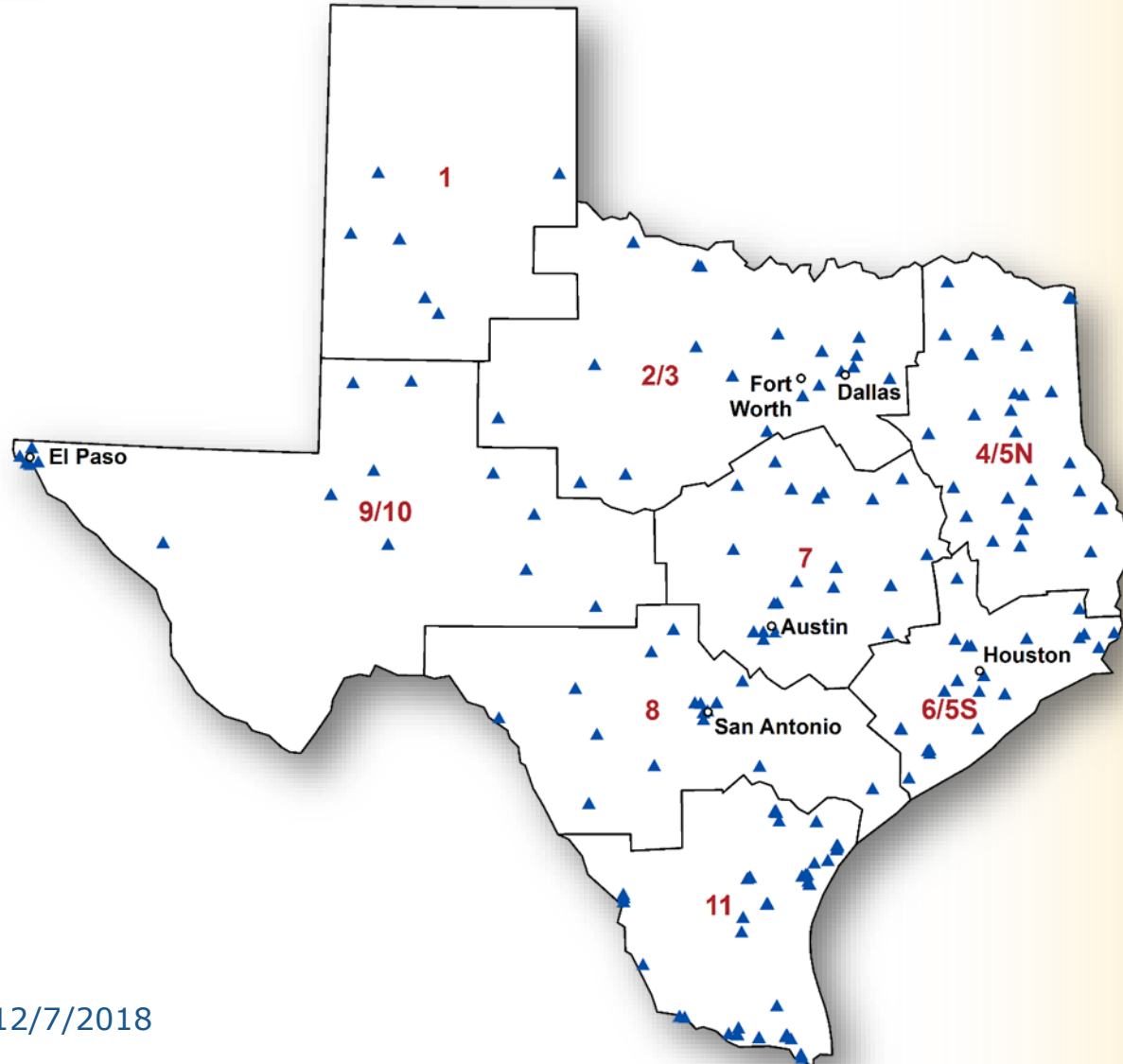
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Facility Overview

August 2016 – December 2017

Facility Type	National	State (Texas)
Total Acute Care Hospitals	970	54
Dialysis	168	23
Long-term Care Facility	289	116
Outpatient	108	4
Total	1535	197

ICAR Visits Aug 2016 –Dec 2017



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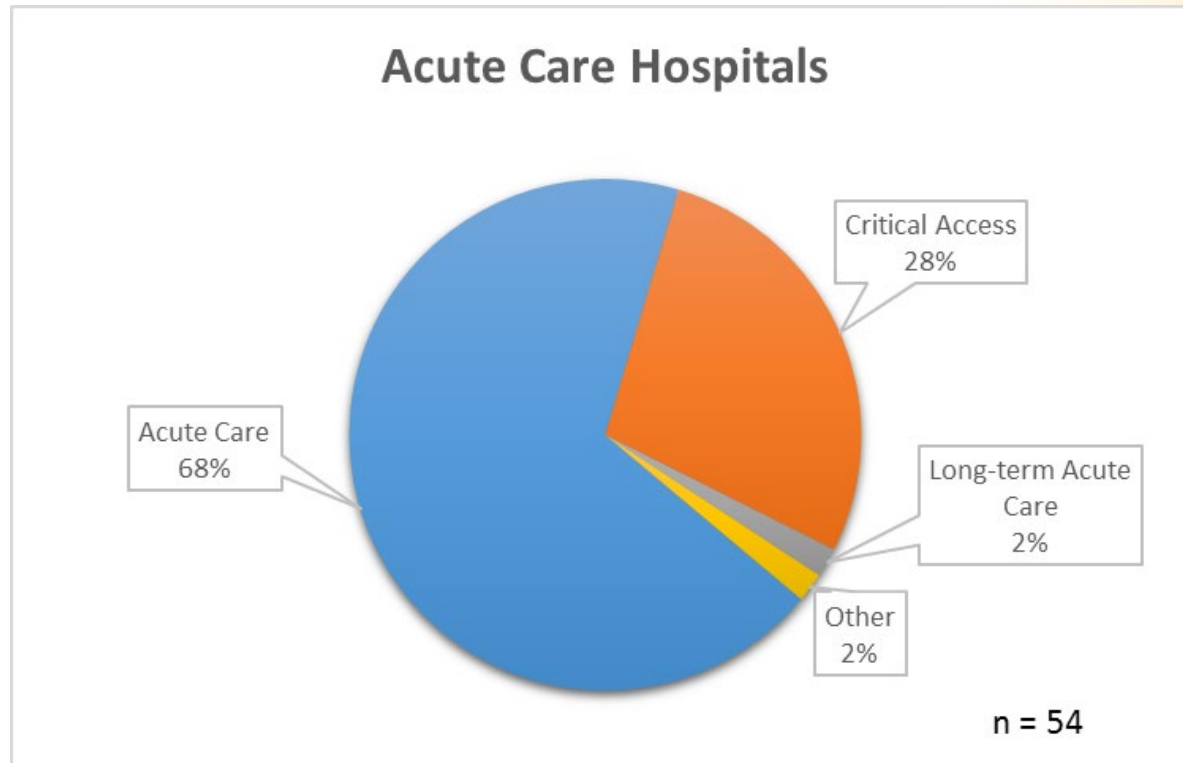
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ICAR Results

**Acute Care Hospitals and Long Term Care Facilities
August 2016 – December 2017**

Demographics



	Mean	Min	Max
Number of Licensed Beds	112	10	557
FTE Infection Preventionist	0.97	0.03	5

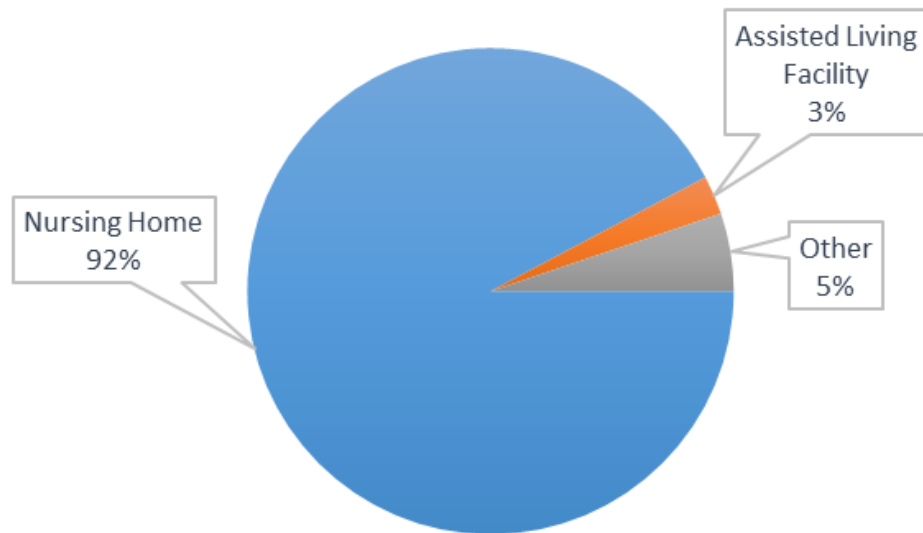


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Demographics

Long-term Care Facilities



n = 116

	Mean	Min	Max
Number of Licensed Beds	108	10	367
Total IC Staff Hours per Week	12	0	42



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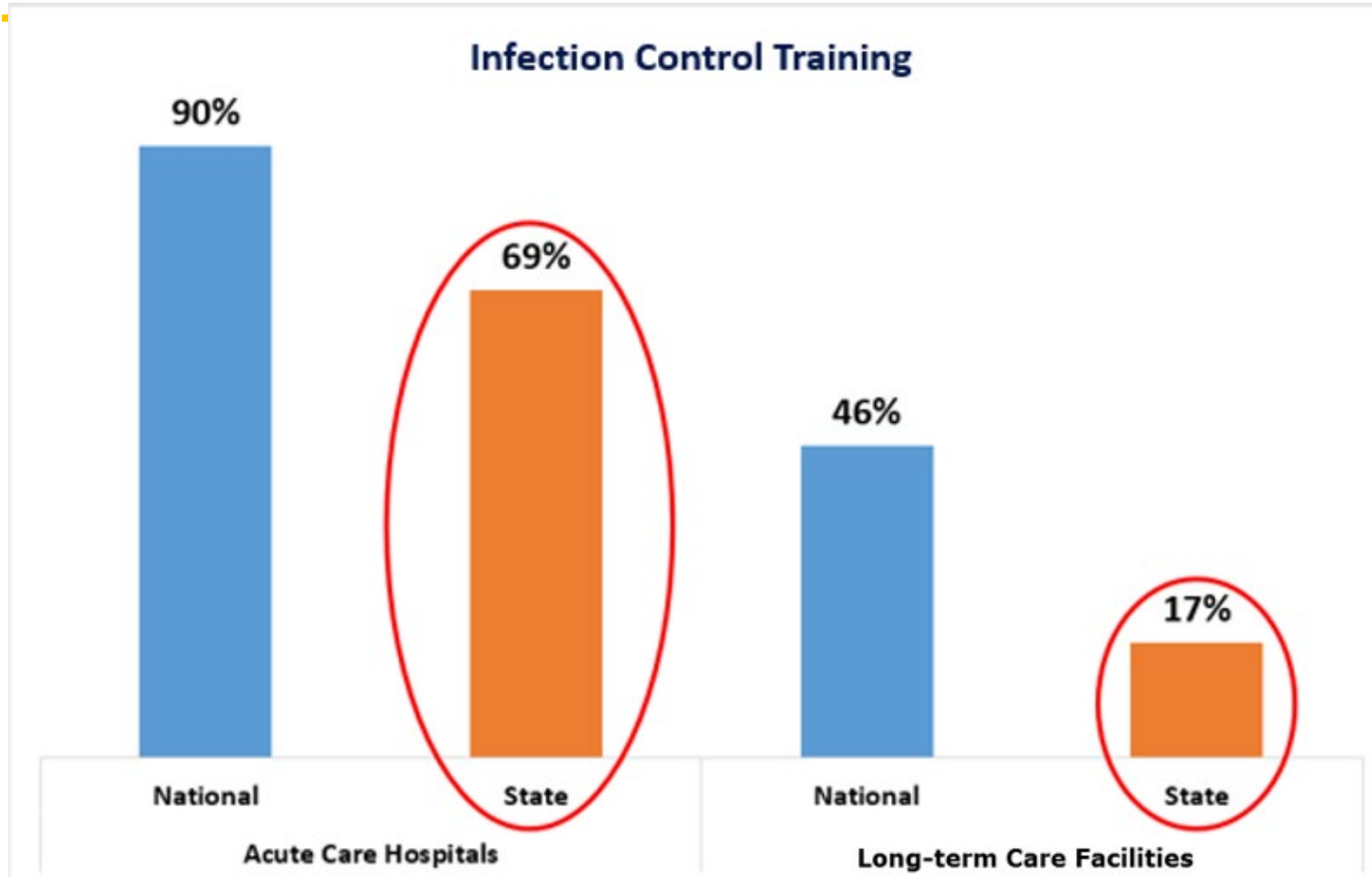
Formal Infection Control Training



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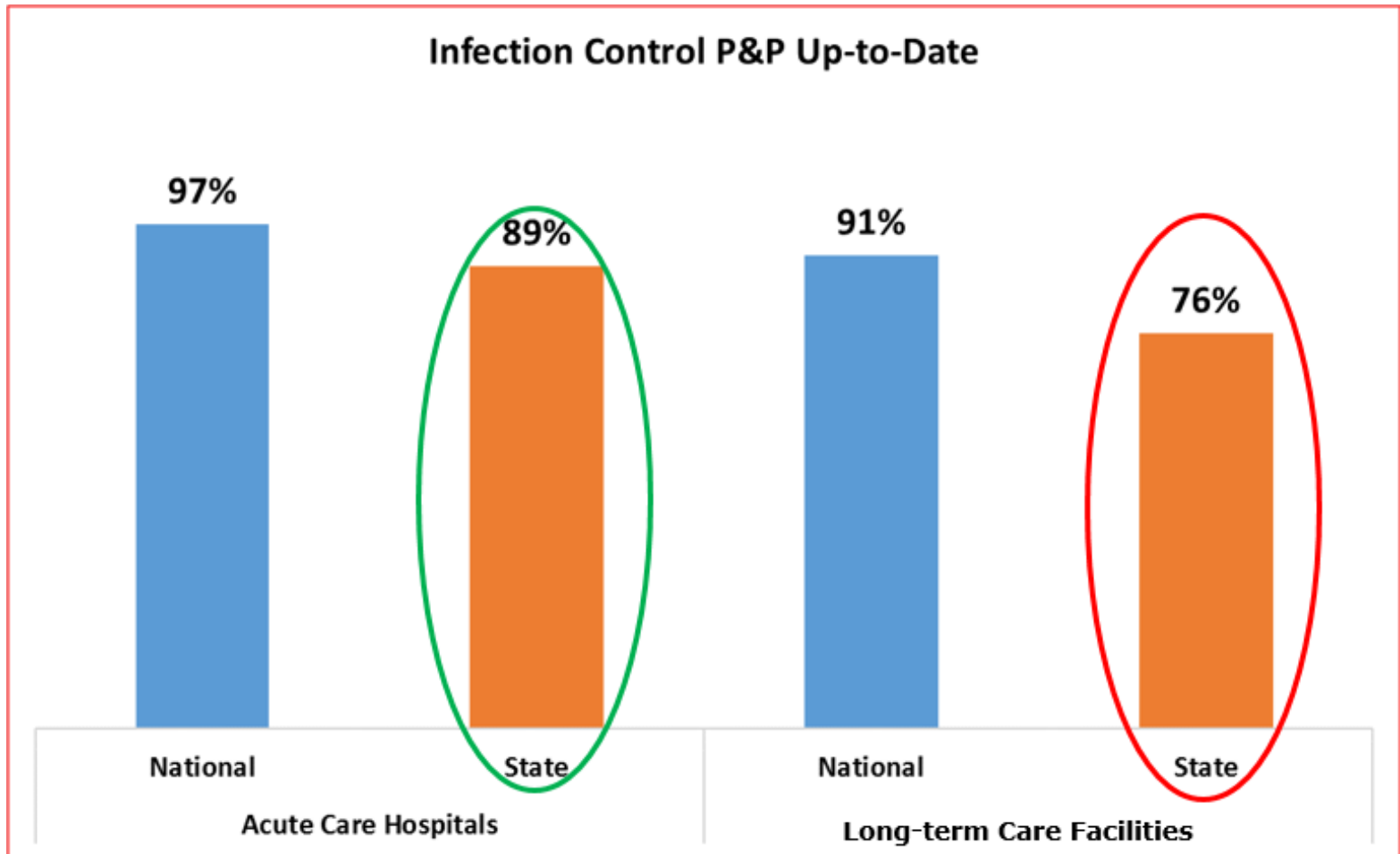
Policies and Procedures



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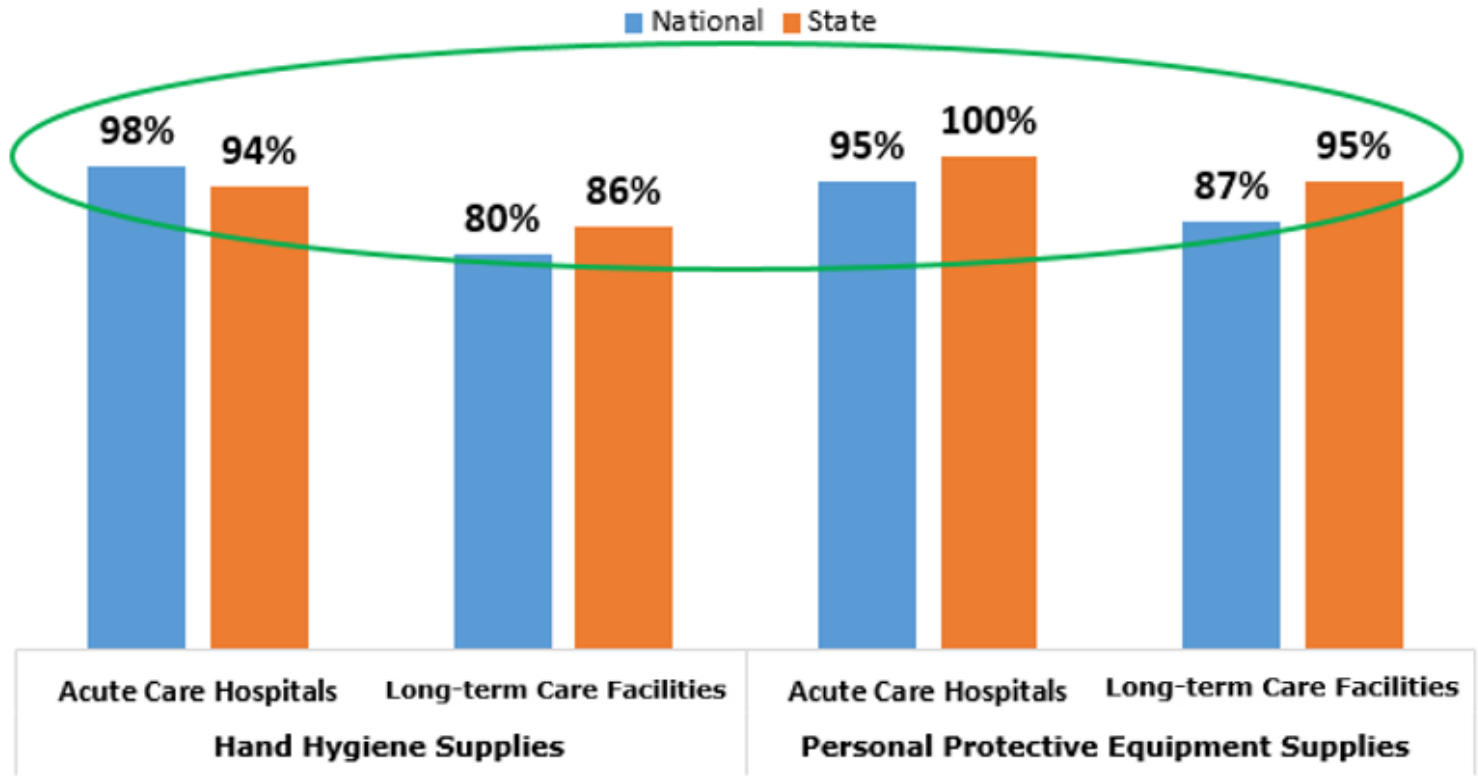
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Standard Precautions

Availability of Supplies



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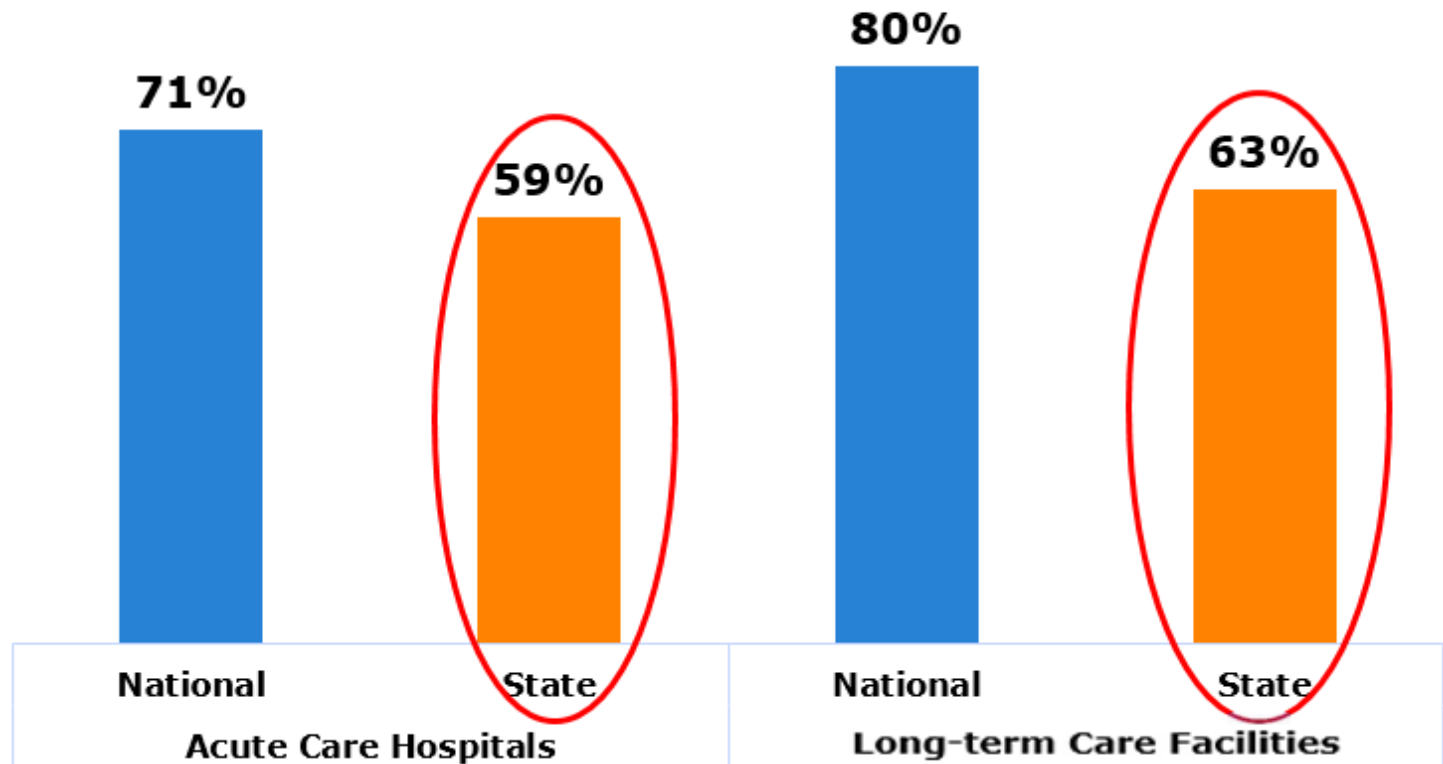
Respiratory Etiquette



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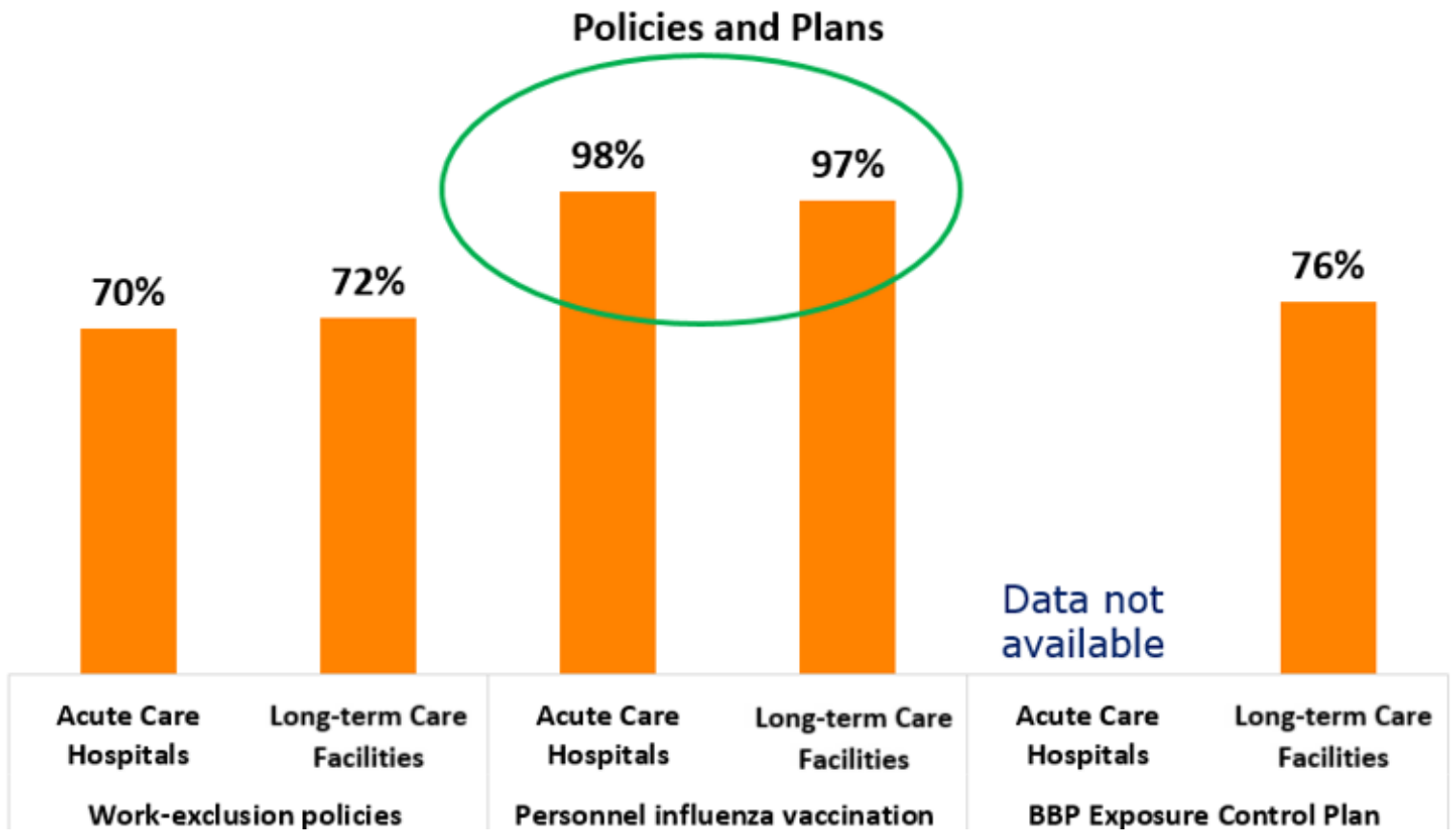
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Elements of Respiratory Etiquette



Employee Health

Texas



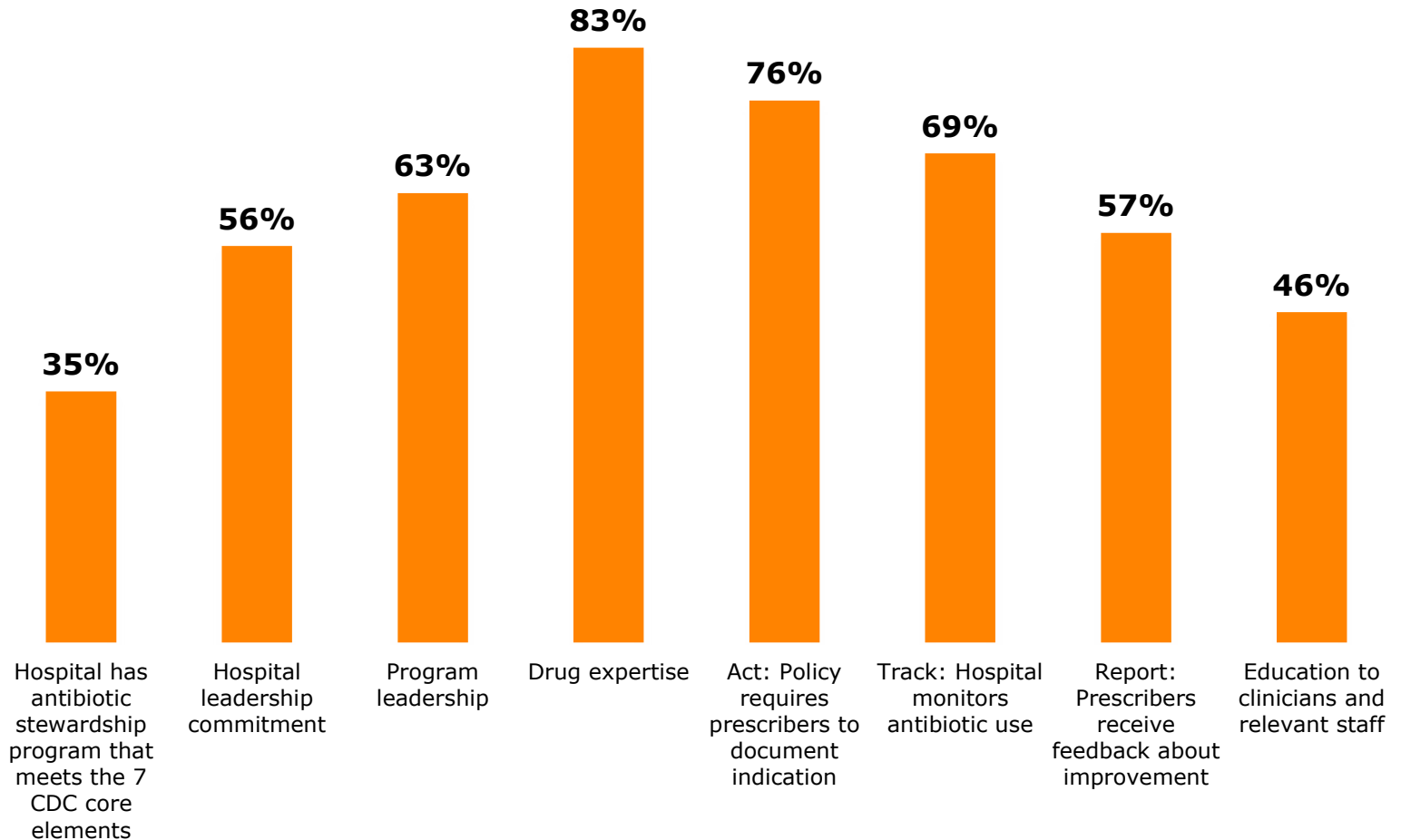


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Antibiotic Stewardship Elements in Acute Hospitals



Additional Measures

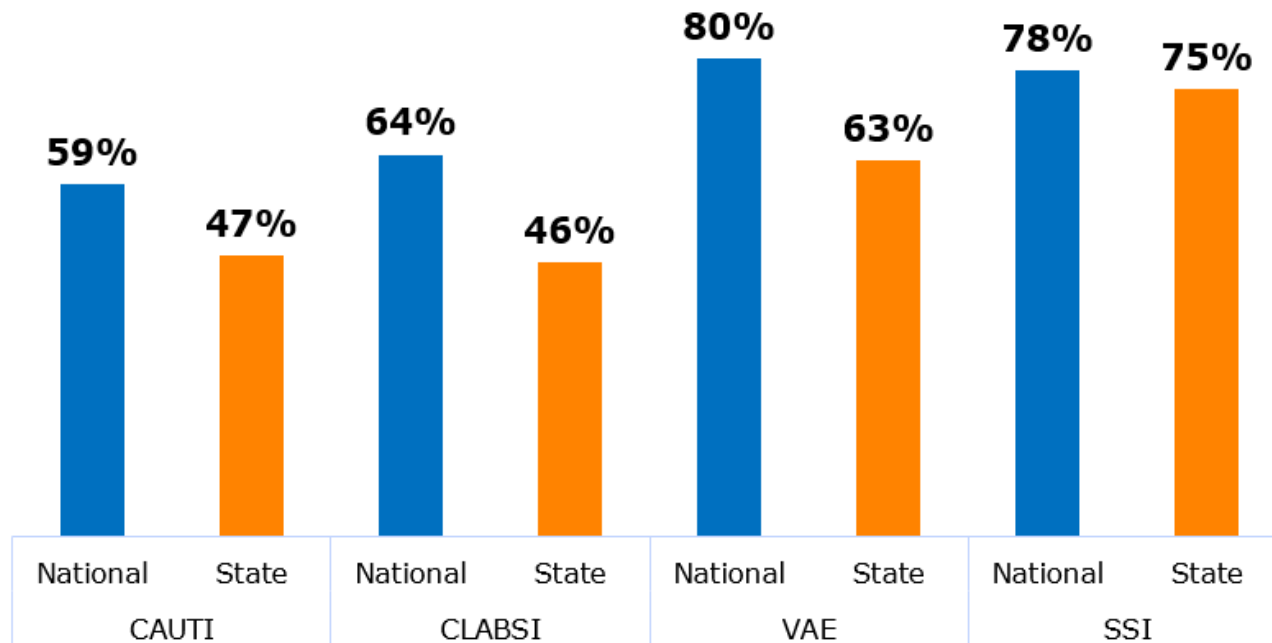


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HAI Prevention Readiness



Key: CAUTI – Catheter-associated Urinary Tract Infection
CLABSI - Central Line-associated Bloodstream Infection
VAE - Ventilator-associated Event
SSI – Surgical Site Infection

Education Programs

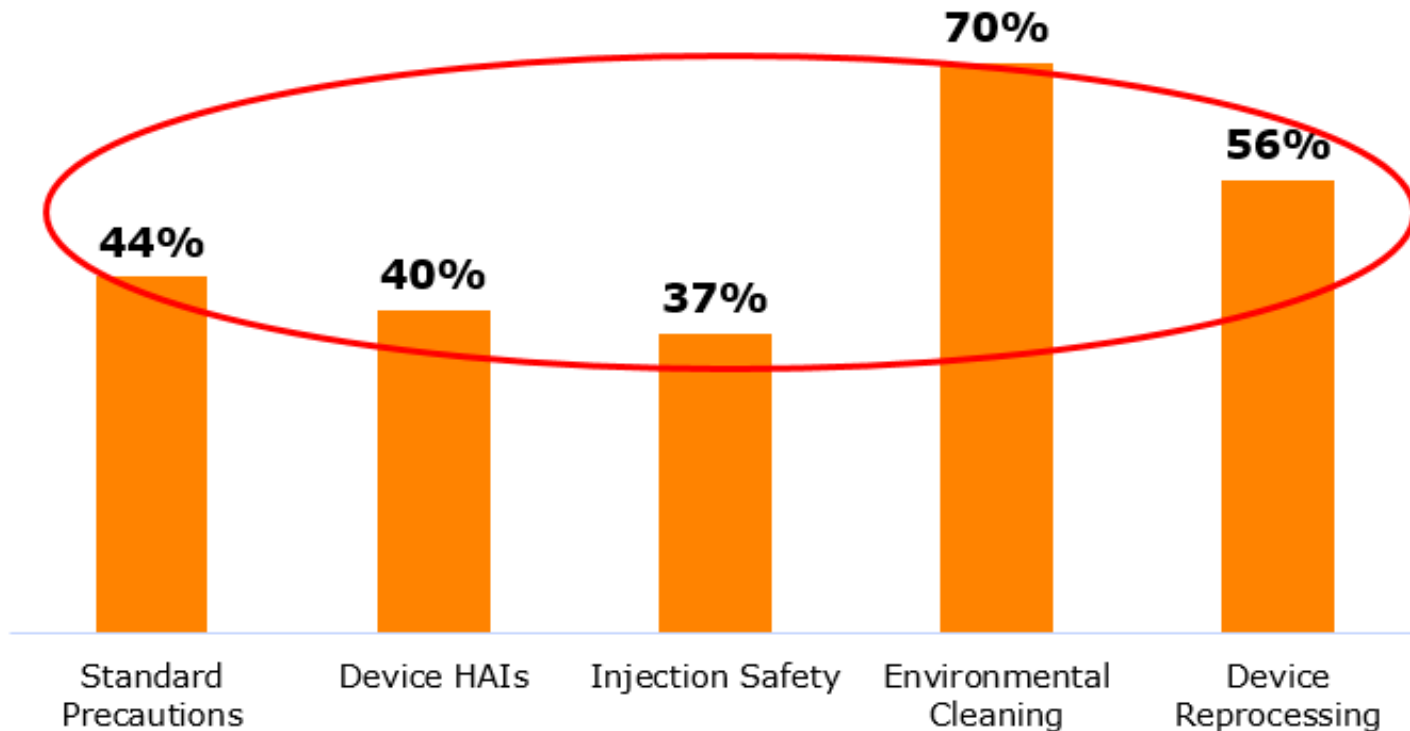


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Acute Care Hospitals

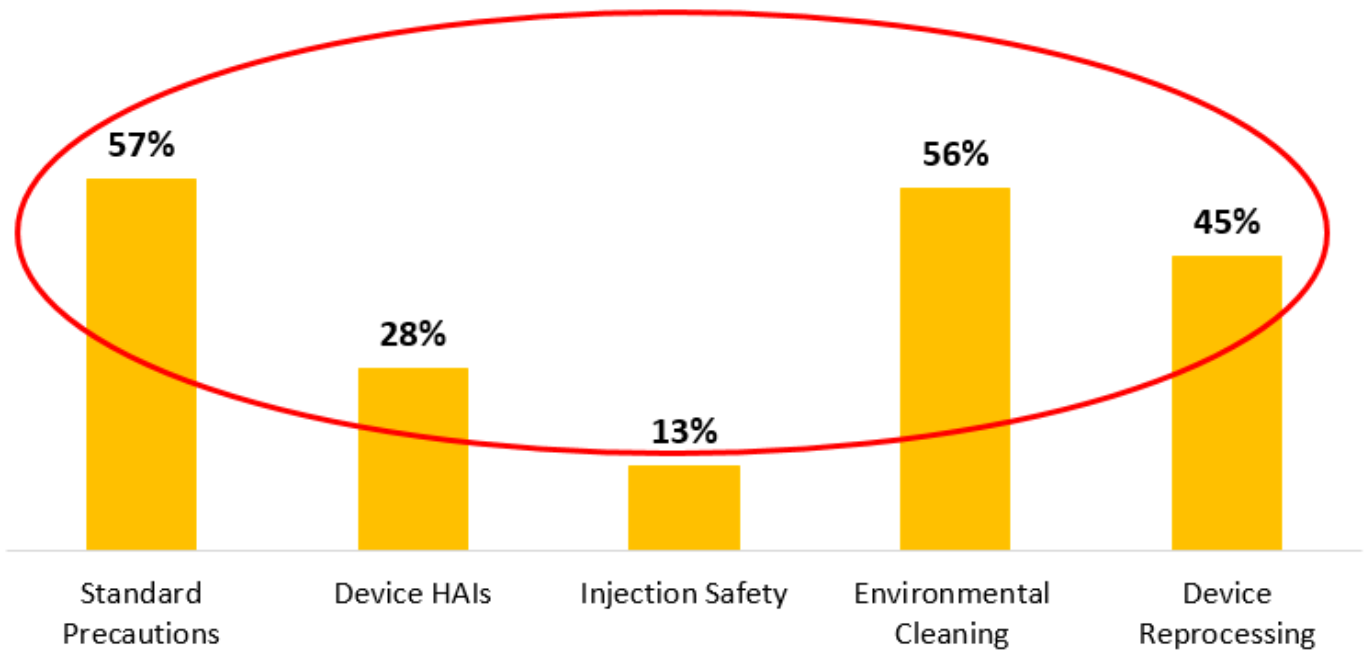
Competency-Based Training Programs



Auditing Process

Acute Care Hospitals

Auditing and Documentation



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Top 3 Strengths

- Infection Control Program and Infrastructure
- Availability of Supplies for Standard Precautions
- Employee Health policies and plans



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Top 3 Gaps

- Antibiotic Stewardship policies and practices
- Auditing and documentation
- Infection Control Training



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Addressing the Gaps

Antibiotic Stewardship



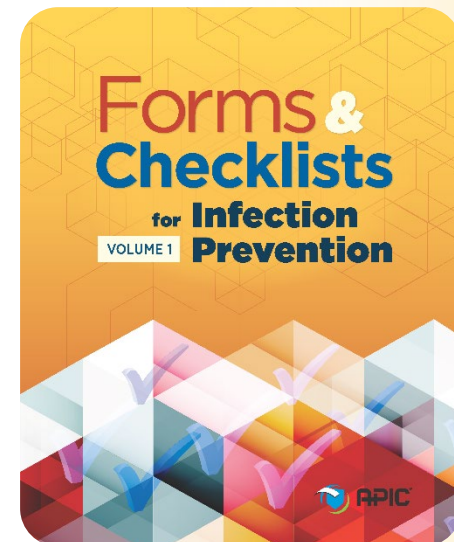
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Addressing the Gaps

Audit and Documentation

- CDC Tools for Healthcare Facilities
 - Acute Care
 - Ambulatory/Outpatient Settings
 - Long Term Care
 - Dialysis Facilities
 - Dental Settings



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Addressing the Gaps

IC Training

- Certification Board of Infection Control and Epidemiology, Inc.
- SHEA Online Learning Center
- APIC Education & Certification
- TSICP Education
- CDC Webinar Series
- NHSN Training



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Addressing the Gaps

Public Health Interventions

Use data for action!

- Provide HAI Support to all types of healthcare facilities
- Continue CIC training efforts
- Collaborate with HHSC
- Conduct educational webinars
- Develop standardized tools



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National Healthcare Safety Network

Jennifer Vinyard, MPH, CIC

Texas Requirements

Central line-associated bloodstream infections (CLABSI) in the following special care settings: adult, pediatric and/or adolescent ICUs & NICUs (Level II/III & Level III Nurseries).

Catheter associated urinary tract infections (CAUTI) in the following special care settings: adult, pediatric and/or adolescent ICUs.

Surgical site infections (SSI)

- CHILDREN'S HOSPITALS: Cardiac procedures, heart transplants, spinal surgery with instrumentation, and VP shunt procedures.
- ALL OTHER GENERAL HOSPITALS & ASCs: Colon surgeries, hip & knee arthroplasties, abdominal & vaginal hysterectomies, vascular procedures, and coronary artery bypass grafts.



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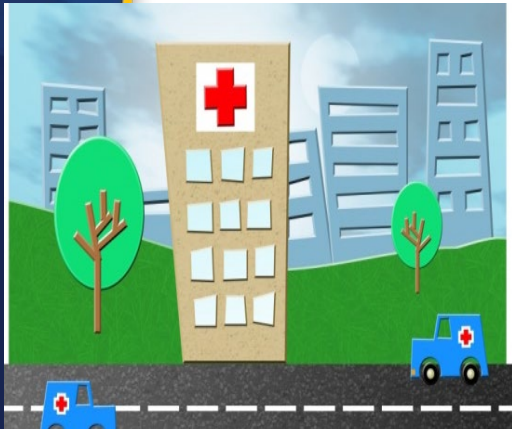
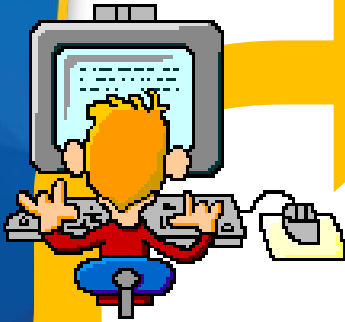
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Reporting Overview



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Alerts regarding data & reports

View reports & make comments



What is the Standardized Infection Ratio?



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$$SIR = \frac{\textit{Observed \# infections}}{\textit{Predicted \# infections}}$$

- A metric for comparing infection occurrence to national benchmark (baseline).
- Predicted # infections based on nationally aggregated risk-adjusted data.
- If > 1 , more infections than predicted.
- If < 1 , fewer infections than predicted.

Change of Baseline

- The original baseline was from 2006-2009.
- New SIR Baseline year = 2015
 - Updated Risk Models
 - Updated how data are parsed
- **How does this affect you?**



Comparison of NHSN baselines – SSI Old Baseline



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- Each NHSN Operative Code had a separate set of Predictive Risk Factors. Procedures/Events were excluded from the SIR calculation if:
 - Any missing risk factors
 - Duration <5 min or exceeds threshold
 - Procedure date is \leq patient DOB
 - Patient's age at procedure is \geq 109 years
 - Wound Class = U
 - Approach = N (FUSN and RFUSN)
 - Spinal Level = N (FUSN only)

Comparison of NHSN baselines – SSI New Baseline

- Separate SIR for Pediatric patients and Adult patients.
- Some changes to procedure specific predictive risk factors.
- New exclusions:
 - Gender = Other or missing
 - Outpatient procedures
 - PATOS=Y
 - Missing closure technique, ASA score
 - BMI <12 or > 60 (adults)
 - BMI < 10.49 or > 65.79 (pediatric)
 - Medical Affiliation or Number of Beds is missing from annual survey



Comparison of NHSN baselines – CLABSI/CAUTI



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- CAUTI/CLABSI
 - Old baseline: Used national rate for each location type to determine the predicted number of infections based on device days.
 - New baseline: Uses regression models to risk adjust based on
 - Location Type
 - Facility Size/Type
 - Medical School Affiliation
 - Birthweight (for NICUs)



CLABSI Example



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SIR for In-Plan Central Line-Associated BSI Data - Overall

As of: June 25, 2018 at 11:18 AM

Date Range: BS1_CLAB_RATESALL summaryYH 2016H1 to 2016H2

if (((bsiPlan = "Y") AND (locationType IN ("CC", "CC_N"))))

summaryYr	infCount	numExp	numCLDays	SIR	SIR_pval	SIR95CI
2016	995	2003.9	967518	0.497	0.0000	0.466, 0.528

National Healthcare Safety Network

SIR for Central Line-Associated BSI Data for Acute Care Hospitals (2015 baseline) - Overall

As of: June 25, 2018 at 11:20 AM

Date Range: BS2_CLAB_RATESALL summaryYH 2016H1 to 2016H2

if (((bsiPlan = "Y")))

summaryYr	infCount	numPred	numclays	SIR	SIR_pval	sir95ci
2016	1044	1143.0	1.07E6	0.913	0.0032	0.859, 0.970

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CLABSI/CAUTI Exclusions



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~~If infCount in this table is less than numExp reported, aggregate data are not available to calculate SIR.~~

~~Lower bound of 95% Confidence Interval only calculated if numExp >= 1. SIR values only calculated if numExp >= 1.~~

~~SIR excludes those months and locations where device days~~

~~At least one month of denominator data in at least one location included in this table were reported using the NHSN sampling method protocol.~~

~~Source of aggregate data: NHSN Report, Am J Infect Control 2009;37:783-805~~

Possible reasons for more device days & infections in SIR calculation

1. This report includes non-MBI CLABSI data from acute care hospitals for 2015 and forward.

2. The SIR is only calculated if the number predicted (numPred) is ≥ 1 . Lower bound of 95% Confidence Interval only calculated when number of observed events > 0 .

3. The number of predicted events is calculated based on national aggregate NHSN data from 2015. It is risk adjusted for CDC location, hospital beds, medical school affiliation type and facility Type.

4. If the risk factor data are missing, the record will be excluded from the SIR.

5. At least one month of denominator data in at least one location included in this table were reported using the NHSN sampling method protocol.

Source of aggregate data: 2015 NHSN CLABSI Data

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CLABSI Example



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SIR for In-Plan Central Line-Associated BSI Data - Overall, by Location Type

As of: June 25, 2018 at 11:18 AM

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if (((bsiPlan = "Y") AND (locationType IN ("CC", "CC_N"))))

locationtype	summaryYr	infCount	numExp	numCLDays	SIR	SIR_pval	SIR95CI
ICU-OTHER	2016	824	1632.6	806925	0.505	0.0000	0.471, 0.540
NICU	2016	171	371.33	160593	0.461	0.0000	0.395, 0.534

National Healthcare Safety Network

SIR for Central Line-Associated BSI Data for Acute Care Hospitals (2015 baseline) - Overall, by Location Type

As of: June 25, 2018 at 11:20 AM

Date Range: BS2_CLAB_RATE\$ALL summaryYH 2016H1 to 2016H2

if (((bsiPlan = "Y")))

locationType	summaryYr	infCount	numPred	numcldays	SIR	SIR_pval	sir95ci
CC	2016	793	824.34	805224	0.962	0.2823	0.897, 1.031
CC_N	2016	171	221.68	160593	0.771	0.0005	0.662, 0.894
CC_ONC	2016	3	9.740	9669	0.308	0.0159	0.078, 0.838
OTHER	2016	2	3.930	5739	0.509	0.3454	0.085, 1.681
STEP	2016	6	5.357	6893	1.120	0.7382	0.454, 2.329
WARD	2016	52	53.327	59680	0.975	0.8735	0.736, 1.269
WARD_ONC	2016	17	24.597	19458	0.691	0.1147	0.416, 1.084

NEW

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CLABSI Example



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SIR for In-Plan Central Line-Associated BSI Data - Overall, by Location Type

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National Healthcare Safety Network

SIR for Central Line-Associated BSI Data (2015 based)

As of: June 25, 2018 at 11:18 AM

Date Range: BS2_CLAB_RATE\$ALL summaryYH 2016H1 to 2016H2

if (((bsiPlan = "Y") AND (locationType IN ("CC", "CC_N", "CC_ONC", "OTHER", "STEP", "WARD", "WARD_ONC"))))

ICU-OTHER now split into 6 new location types

SIR for Acute Care Hospitals

locationType	summaryYr	infCount	numPred	numcldays	SIR	SIR_pval	sir95ci
CC	2016	793	824.34	805224	0.962	0.2823	0.897, 1.031
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CLABSI Example



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CLABSI Example



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National Healthcare Safety Network

SIR for Central Line-Associated BSI Data (2015 baseline) - Overall, by Location Type

As of: June 25, 2018 at 11:20 AM

Date Range: BS2_CLAB_RATE\$ALL summaryYH 2016H1 to 2016H2

if (((bsiPlan = "Y")))

Number of predicted infections is much lower → SIR higher

locationType	summaryYr	infCount	numPred	numcldays	SIR	SIR_pval	sir95ci
CC	2016	793	824.34	805224	0.962	0.2823	0.897, 1.031
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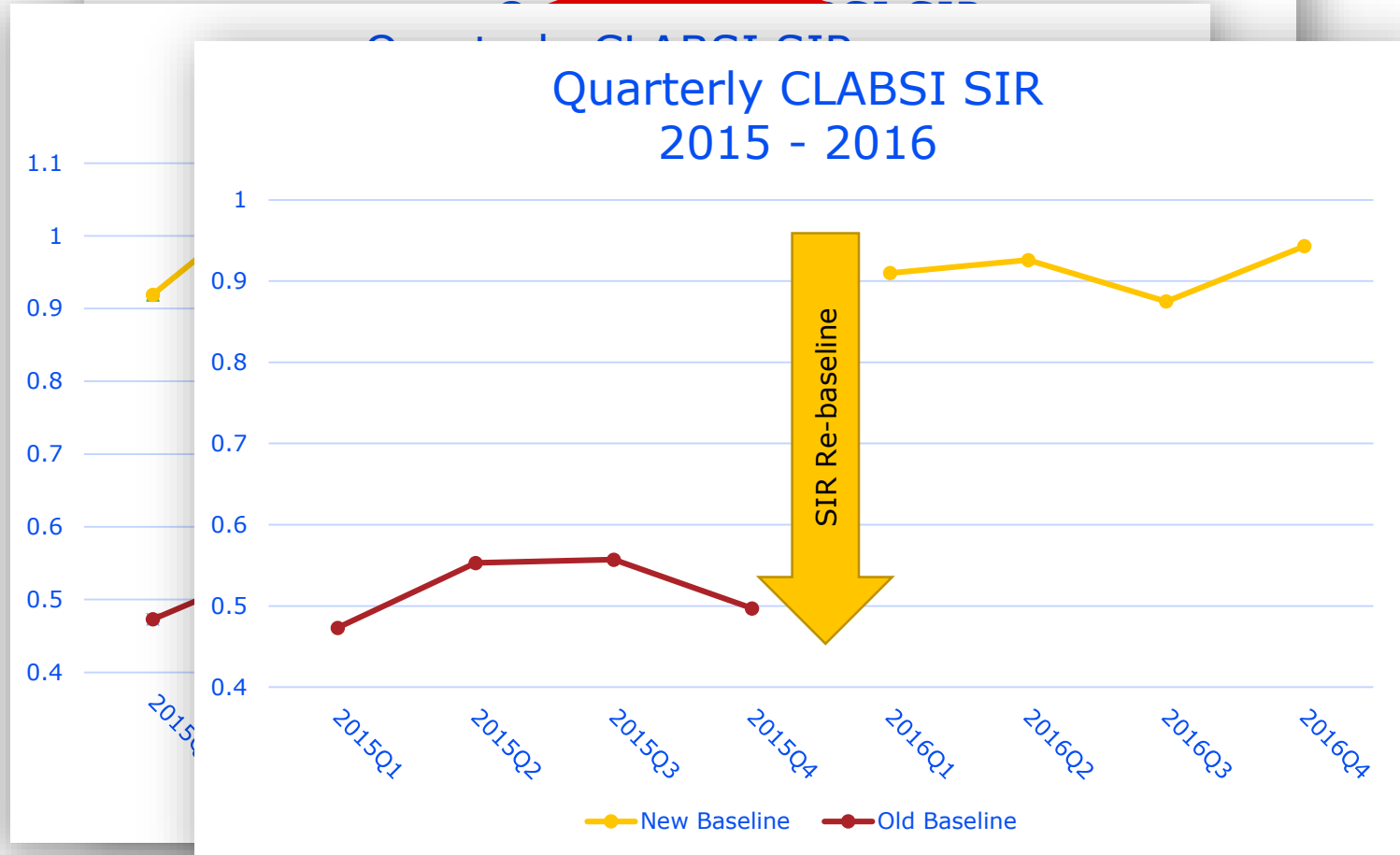
How to trend data?



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Data Uses



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- Facility Uses
 - Determine whether there is a higher burden of HAI than baseline
 - Trending – are improvements being made?
 - Identify locations that need improvement
- State Uses
 - Annual Aggregated Data – trending, identify which regions need additional support
 - Identify specific facilities that may need extra assistance
 - Publically post data for consumer use
- Public/Consumer Uses
 - To empower patients to make informed choices regarding where they receive their healthcare



Facility-Specific Reports

Facility-Specific Health Care Safety Report - Technical Version



Reported by the Texas Department of State Health Services

Time Period: July - December [Final] 2014

Report current as of: 05/04/2015 02:30 PM


Data shown in this report came from the National Healthcare Safety Network (NHSN).

Central Line-Associated Bloodstream Infection (CLABSI) Standardized Infection Ratio (SIR)

Unit Type	No. of Central Line Days	Number of Infections		SIR and 95% Confidence Interval			SIR Interpretation	No. of CLABSIs that Contributed to the Patient's Death
		Observed	Predicted	SIR	Lower	Upper		
NICU	2533	1	6.622	0.151	0.008	0.745	 Significantly fewer infections observed than predicted, based on the 2006 - 2008 national baseline	0
ICU	1733	1	2.6	0.385	0.019	1.897	 No significant difference between the number of observed and predicted infections, based on the 2006 - 2008 national baseline	0

* NOTE: The SIR Statistical Interpretation only takes into consideration the SIR values. The facility is responsible for providing any additional explanation regarding deaths and if provided, can be found below in the Facility Comments Section.

Catheter-Associated Urinary Tract Infection (CAUTI) Standardized Infection Ratio (SIR)

Unit Type	No. of Urinary Catheter Days	Number of Infections		SIR and 95% Confidence Interval			SIR Interpretation	No. of CAUTIs that Contributed to the Patient's Death
		Observed	Predicted	SIR	Lower	Upper		
ICU	1850	8	2.22	3.604	1.674	6.843	 Significantly more infections observed than predicted, based on the 2009 national baseline	0

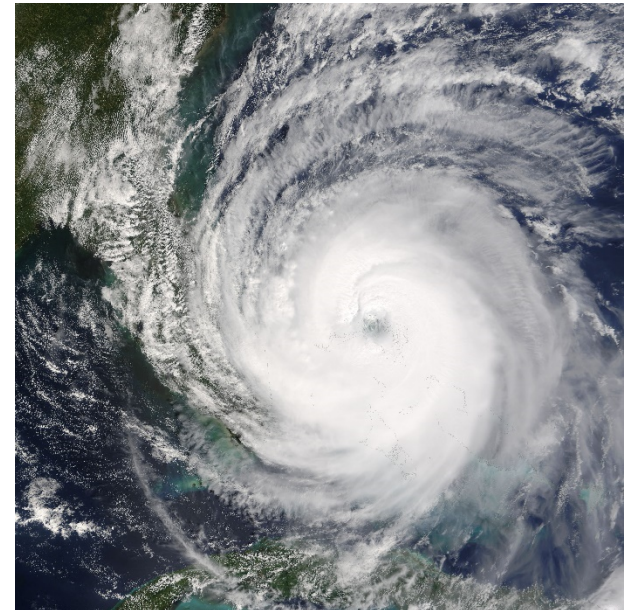
Harvey Disaster Proclamation



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- Data reporting for Texas was suspended due to Hurricane Harvey. (CMS reporting still required)
- Disaster Proclamation extended through June 2018 (as of 6/15/18).
- Facility-Specific reports will not contain data – will state that facilities were not required to report.
- Aggregated (overall State-level) data may be published with caveats.





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Melba Zambrano, MSN-IC, CIC

What is TAP?

Quality Improvement

- Uses data for action
- Prioritizes prevention efforts
- Targets location with greatest impact
- Standardized method to identify gaps
- Resource to address gaps



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Standardized Infection Ratio



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$$\text{SIR} = \frac{\text{Observed \# HAI}}{\text{Predicted \# HAI}}$$

Facility Org ID	Summary YR	Events	Number Predicted	Urinary Catheter Days	SIR
123456	2017	20	5	3850	3.1

National vs. Texas

2015 DATA						
HAI TYPE	# ACHs REPORTING*	2015 SIR DISTRIBUTION [†]			2015 STATE SIR	2015 NAT'L SIR
		MINIMUM	MEDIAN	MAXIMUM		
CLABSI	331	0.041	0.879	1.912	0.970	0.994
CAUTI	360	0.000	0.770	1.728	0.907	0.993
VAE	127	0.000	0.535	1.647	0.729	1.000
SSI, Abdominal Hysterectomy	278	—	—	—	0.859	1.003
SSI, Colon Surgery	273	0.000	0.787	1.927	0.962	0.999
<i>C. difficile</i> Events	359	0.270	0.884	1.544	0.927	0.993
MRSA Bacteremia	354	0.000	0.784	1.942	0.911	0.998



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CAD



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CAD = Observed # HAI - (Predicted # HAIs x SIR goal)

- Cumulative Attributable Difference (CAD)
- Show difference between the number of observed infections and predicted infections multiplied by a SIR goal
- CAD can be positive (excess infections) or negative

Reduction Goal

Facility A:	Observed =50	Predicted = 70.8	SIR =0.71
Reduction Goal	SIR Goal	CAD Formula: Observed- (Predicted X SIR goal)	CAD
0%	1.0	$50 - (70.8 \times 1)$	-20.8
*25%	0.75	$50 - (70.8 \times 0.75)$	-3.10
50%	0.50	$30 - (70.8 \times 0.50)$	14.60
75%	0.25	$50 - (70.8 \times 0.25)$	32.3



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CAD Location Level









Facility A	Observed	Predicted	SIR	SIR Goal	CAD
Ward	20	10	2.0	0.50	15
ICU	30	60	0.5	0.50	0
Facility	50	70	0.71	0.50	15



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Facility Type Reports

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



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Target: Generating Reports

TAP Report

- Utilize 2015 baseline data
- Generated by time period
- Recommend time period of at least one quarter
- Preferably filters should not be used
- Selecting HHS Goal
 - CAUTI SIR goal: 0.75
 - CDI SIR goal: 0.70
 - CLABSI SIR goal:0.50



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Facility & Location Rank

facRank	orgID	Name
1	1000	St. Petersburg
2	10401	Blank Medical Center
3	90002	ICU Hospital
4	10064	Great Care Center
5	8888	Hospital of Texas

Facility name	Facility CAD	Location Rank	Location
Blank Medical Center	6.35	1	ICU
		2	6 West
		3	Step1
		4	TELE

Assess: Assessment Tool

Surveys

- Administered on-site or remotely
 - Adobe PDF fillable form
 - Paper survey
 - Survey Monkey
- Minimum of 30 surveys per facility
- Indicative of staff knowledge
 - No, never, rarely, or sometimes
 - Action Information



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opportunities and next steps.

Instructions for Submission:

Do you have a Desktop Email Application?
(e.g., Outlook, Windows Live Mail)

- 1) Click SUBMIT
- 2) Select the top radio button (Desktop Email Application)
- 3) Click OK

This will automatically generate an email with the completed form attached

Do you have a web-based email address?
(e.g., Gmail, Yahoo)

- 1) Click SUBMIT
- 2) Select the bottom button (Internet Email)
- 3) Copy the email address listed in the text next to the radio button
- 4) Click OK
- 5) Save the document to your computer
- 6) Open your web based email, attach the file, and send to the copied email address

Are you having trouble submitting?
(e.g., No email application, Firewall is blocking submission)

- 1) Click the PRINT button
- 2) Print to a local printer
- 3) Give completed form to your facility Point of Contact

For Internal Use Only

Instructions for Administration:

This Facility Assessment Tool should be administered to a variety of staff and healthcare personnel at different levels of the organization and/or unit (i.e., frontline providers, mid-level staff, and senior leadership). This tool also should be administered to Environmental Services personnel as they too play a critical role in CDI prevention. This assessment captures healthcare personnel's knowledge, attitudes, and perceptions of infection prevention practices. The greater number of assessments collected, the greater the ability to identify gaps and target prevention.

This Assessment Tool is a component of the Targeted Assessment for Prevention (TAP) Strategy. For more information, visit <http://www.cdc.gov/hai/prevent/tap.html>

This tool can be distributed and returned via email. Prior to distribution, enter the email address to which the completed assessments should be returned and Save the document (send this Saved version to respondents). When respondents "Submit", the form will be automatically sent to the email address specified below.

Return Email Address:

TAP Tools



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Date of Assessment: _____

Facility Name or ID: _____

Facility Type: _____ Other, Please Specify: _____

Unit Name or ID: _____

Unit Type: _____

Title or role of person completing tool: _____ Other, Please Specify: _____

Years of experience at facility: _____ (Numeric Response)

I. General Infrastructure, Capacity, and Processes	Response	Comments (and/or "As Evidenced By")
1. Does your facility's senior leadership actively promote CDI prevention activities?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unk	
2. Is unit-level leadership involved in CDI prevention activities?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unk	
3. Does your facility have a team/work group focusing on CDI prevention?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unk	
4. Does your facility have a staff person with dedicated time to coordinate CDI prevention activities?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unk	
5. Does your facility have a nurse champion for CDI prevention activities?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unk	
6. Does your facility have a physician champion for CDI prevention activities?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unk	

CAUTI

CLABSI

CDI

Excel Spreadsheet

Ia. Facility Staff		
3. Does your facility currently have a team/work group focusing on CAUTI prevention?	Infrastructure Comments	4. Does your facility have a staff person with dedicated time to coordinate CAUTI prevention activities?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>



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Feedback Report

Facility Name						
Catheter-associated Urinary Tract Infection (CAUTI) Facility Assessment Tool—Feedback Report						
Date Range:	X	X	X	X	1.00	X
Enter Date Range of Data	Number of healthcare facility-onset CAUTIs	Number of predicted healthcare facility-onset CAUTIs	Facility Cumulative Attributable Difference (CAD), or the number of infections the facility would have needed to prevent to achieve an HAI reduction goal SIR of 0.75	Healthcare facility-onset CAUTI Standardized Infection Ratio (SIR)	2014 National healthcare facility-onset CAUTI SIR	2014 State healthcare facility-onset CAUTI SIR
				SIR >1.0 indicates more infections than predicted		
Assessment Overview		Leading*		Lagging†		
# Collected: 0						
# Analyzed: 0						
Overall Mean Score: out of 52, or						
<p>Note: If this report represents fewer than 30 assessments, results may not be fully representative of the awareness and perceptions of infection prevention practices among healthcare personnel. Scoring and results are for the purpose of internal quality improvement and should <u>not</u> be used as a method to benchmark against other units or facilities.</p>						
Selected Deep Dives – Top Opportunities for Improvement ‡						
I. General Infrastructure	II. Appropriate Indications for Insertion	III. Aseptic Insertion	IV. Proper Catheter Maintenance	V. Timely Removal	VI. Appropriate Urine Culturing Practices	



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Response Rates

Responses Per Question

Please note: Selected LEADING results are highlighted in green (>75% Yes, or >75% for sum of Often+Always). Selected LAGGING results are highlighted in red (>33% Unknown, >50% No, >50% for sum of Never+Rarely+Sometimes+Unknown). It is strongly encouraged that each unit and facility review all of the data available to target other potential opportunities for improvement, aligning to ongoing and/or planned areas for intervention where possible. Data may not be representative of actual practices, as these are self-reported respondent perceptions.

I. General Infrastructure, Capacity, and Processes

Question	Yes	No	Unknown
1. Does your facility's senior leadership actively promote CAUTI prevention activities?	0%	0%	0%
2. Is unit-level leadership involved in CAUTI prevention activities?	0%	0%	0%
3. Does your facility currently have a team/work group focusing on CAUTI prevention?	0%	0%	0%
4. Does your facility have a staff person with dedicated time to coordinate CAUTI prevention activities?	0%	0%	0%
5. Does your facility have a nurse champion for CAUTI prevention activities?	0%	0%	0%
6. Does your facility have a physician champion for CAUTI prevention activities?	0%	0%	0%
Does your facility provide training to all healthcare personnel* on:			
*For personnel given the responsibility to insert, assist with insertion, or maintain indwelling urinary catheters.			
7. Aseptic technique for urinary catheter insertion?	0%	0%	0%
8. Proper urinary catheter maintenance procedures (e.g., aseptic emptying of drainage bag, maintaining a closed drainage system, maintaining unobstructed urine flow)?	0%	0%	0%
9. Proper placement of the drainage bag (also including transport personnel and all others involved in moving patients)?	0%	0%	0%



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Prevent: Resources

1. [TAP CAUTI Toolkit Implementation Guide: Links to Example Resources](https://www.cdc.gov/hai/prevent/tap/cauti.html)(<https://www.cdc.gov/hai/prevent/tap/cauti.html>)
2. [TAP CDI Implementation Guide: Links to Example Resources](https://www.cdc.gov/hai/prevent/tap/cdiff.html)(<https://www.cdc.gov/hai/prevent/tap/cdiff.html>)
3. [TAP CLABSI Implementation Guide: Links to Example Resources](https://www.cdc.gov/hai/prevent/tap/clabsi.html) (<https://www.cdc.gov/hai/prevent/tap/clabsi.html>)



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Texas TAP Strategy

Measures	No. TAP Assessments Completed
CLABSI	11
CAUTI	8
Total:	19



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Number of facilities identified includes SIR > 1 & CAD > than 2 and exclude Houston facilities & facilities participating within 1 year.

Implemented

1. Focused on Gaps identified
2. Implementing CLABSI bundle
3. Department Specific In-services
4. Equipment and new product training
5. Creation of PICC team
6. Implement Nurse driven CAUTI protocols
7. Review products- suture-less adhesives, non-indwelling



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Success Stories

“We are working hard on preventing CAUTIs and the assessment you did was very helpful!”

“This was helpful, we found the same type of stuff in our own drill downs so your findings are reassuring that’s what we should focus on.”

“Having recommendations from DSHS got everyone’s attention”.

74% of facilities that participated in the TAP Strategy saw a decrease in their SIR and CAD.



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Questions?

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Thank you!

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