Infection Control Risk Mitigation and Implementation of Evidence-Based Recommendations in Long-Term Care Facilities

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BACKGROUND

- Nebraska (NE) Infection Control Assessment and Promotion Program (ICAP) is supported by the Nebraska DHHS HAI program via a CDC grant and works to assess and improve infection prevention and control programs in all types of healthcare facilities.
- Other state health departments also have also implemented Infection Control Assessment and Response (ICAR) programs in their states.
- Limited data exist on the effectiveness of the ICAR program on improving infection prevention (IP) practices in healthcare facilities.
- We studied the effectiveness of the Nebraska ICAR team intervention model (peer-to-peer feedback and coaching using evidence-based guidance) on mitigating IP gaps in long-term care facilities (LTCFs).

METHODS

- NE ICAP conducted on-site assessments of IP programs in 45 long-term care facilities (LTCFs) between November 2015 and August 2017.
- Following the assessments, subject matter experts (SMEs) provided individualized and prioritized evidenced-based recommendations (EBRs) for improvement to each facility based on their identified IP gaps.
- Using a standardized questionnaire, follow-up phone assessments were conducted with LTCF one-year post visit to evaluate implementation of the EBR and factors that enhanced or posed barriers to initiation or completion of EBRs.
- Descriptive analyses were performed to examine EBR implementation in 31 LTCF that received follow-up assessments as of June 2018 (69% of the total LTCF visited).

RESULTS

- Overall, 45 LTCF were assessed (Table 1).
- Follow-up phone assessments were completed with 31 LTCF during which 371 EBR were discussed. Recommendations reviewed ranged from 3 to 26 per LTCF (median 12) receiving follow-up phone assessments (follow-up phone assessments for remaining facilities are planned to be completed by March 31, 2019).
- The majority of the 371 recommendations (n=225, 61%) were either completely or partially implemented by the time of the follow-up phone assessment (Figure 1).
- Of the 146 EBR not implemented, 89 were planned to be implemented and 20 were not planned to be implemented. Decisions were unknown for the remaining 77 EBR not implemented.
- There were 12 specific areas that required a mitigation recommendation in at least 33% of assessed LTCF (Table 2).
- The majority of these recommendations were either partially or completely implemented by most of the facilities (Table 2).
- Factors that enhanced or posed barriers to initiation or completion of implementation are presented in Figure 2.
- Implementation of EBR most frequently required additional staff training followed by review of policies and procedures (Table 3).
- Figure 3 displays resources used by facilities to support successful EBR implementation.

CONCLUSIONS

- Numerous infection control gaps exist in long-term care facilities. Peer-to-peer feedback and coaching by subject matter experts (SMEs) facilitated implementation of many EBR directed towards mitigating identified gaps.
- On-site coaching from SMEs at NE ICAP raised awareness of infection control gaps not previously identified within facilities, which enhanced EBR implementation.
- The NE ICAP team has created many infection prevention and control-related tools and templates based on the need identified during the site visits and the follow-up calls. These tools and many other resources are now available on the ICAP website (https://icap.nebraskamed.com).

DISCLOSURES

The authors of this study have nothing to disclose related to the content of this poster.