Background

- Clostridium difficile infection (CDI) caused nearly 500,000 illnesses with 29,000 deaths in the United States
- Preventing hospital-associated Clostridium difficile infection (HA-CDI) is crucial to modern healthcare systems for reducing mortality, healthcare costs and length of stay
- There are multiple risk factors for CDI transmission in healthcare settings:
  - Failure to comply with hand hygiene
  - Ineffective equipment and surface cleaning
  - Diagnosis delays

Objective

- Promptly engage hospital staff in discussion after HA-CDI to identify gaps and reduce infection rates in our facility.

Methods

- After identifying a HA-CDI, infection control and the unit’s clinical nurse specialist coordinated an interdisciplinary huddle
- Nursing, environmental services, physicians, pharmacy and ancillary staff were invited to attend the huddle
- A CDI huddle guide (Figure 1.) was utilized to prompt conversation around the case and collect data about the patient: including risk factors such as advanced age, antibiotics usage and previous admission from an outside facility
- Other variables including environmental factors, hand hygiene, and any missed opportunities or barriers to diagnosis were identified

Results

- Completed 48 CDI huddles over the course of 14 weeks
- 40% of cases experienced a delay in diagnosis
- 63% of patients with HA-CDI had two or more risk factors (i.e. antibiotics use, ≥65 years of age, admitted from an outside facility etc.)
- Clinical team member present for 52% of huddles (n=25)
- 85% of patients received verbal screening questions during the nursing admission history (n=41)

Conclusions

- Engaging staff in CDI huddles revealed delays in testing and gaps in education, prompting implementation of a nursing driven diarrhea decision tree
- The huddles increase awareness around CDI transmission, further education to clinical and support staff, and empower unit staff to be prevention champions

Disclosures

Nothing to disclose