Real Time CLABSI Case Reviews at HCMC

Mary Ellen Bennett
Steph Laskowski
RCA vs Real Time Case Review

Similar: event review with stakeholders, no blame, gives ideas on what could be done better, focus is on systems and processes

RCA
- Know the error and dissect it
  - Med error
  - Fall
- Use form from The Joint Commission
- Formal

Case Review
- Know outcome
- Compare against best practice
- Address patient related issues
- Less formal
Burning Platform
CLABSI Cases are not Zero

CLABSI

Lower Numbers are Better

HENNEPIN COUNTY MEDICAL CENTER

UNIVERSITY OF MINNESOTA MEDICAL CENTER, FAIRVIEW

NORTH MEMORIAL MEDICAL CENTER

Minnesota

Data reflects public reporting @HCMC from: MICU, SICU, NICU and PICU

Data last updated by CMS April 2014
for time period July 1, 2012 - June 30, 2013
Program

1. CLABSI surveillance performed daily
2. Case review with in 48 hours of identifying case
3. Participants chosen and invited
4. Template filled out by Infection Prevention and sent to attendees. Attendees are to look at their portion of patient care before the meeting
5. Review led by Infection Prevention with assistance from Quality Department
6. Can review insertion video if inserted in ED
Central Line-Associated Bloodstream Infection (CLABSI) Real-Time Review:

Standard Work

1. CLABSI is identified by Infection Prevention
2. Infection Prevention completes an on-line event report
3. Infection Prevention gathers background information on patient and event – enters information into event review form
4. Infection Prevention contacts the following parties to convene an event review within 48-72 hours:
   a. Required attendees:
      i. Attending physician of patient at the time the positive blood culture was collected
      ii. Nursing Director of unit of attribution
      iii. Nurse Manager of unit of attribution – nurse manager will bring involved staff or if needed, interview prior to meeting
      iv. Medical Director of unit of attribution
      v. Stephanie Laskowski, Infection Preventionist
      vi. Dr. Margaret Simpson, medical chair of Infection Prevention Committee
      vii. Physician that inserted central line (if central line was placed within 7 days of the positive blood culture)
      viii. ED faculty present at line insertion (if central line inserted in the ED within 7 days of positive
First Case

- Femoral cooling catheter placed in ED
- Should come out <24 hours after not needed
- Taken out 2 days late

- Daily rounds critical every day, remove lines
- Shows importance of getting lines out
- Femoral insertion needs 3 minutes CHG scrub
- Nursing documentation not 100%
- Eye opening for MDs and Nursing
Picking Attendees

- Physician inserting line if <7 days from insertion and their Attending Faculty
- Attending physician
- Observer (for 2 person central line insertion)
- Nurse Manager and Director on unit
- Nurse caring for the patient
- Medical Director of Unit
- Infection Prevention and Quality
- Infection Prevention’s Medical Director
What is Assessed

- Insertion procedure
  - Was line emergent
  - Was line present on admission
    - Was the PICC Team called to evaluate the line
- Biopatch placed?
- Port prepping (scrub the hub)
- CHG bathing done?
- Documentation by physicians and nursing
- Daily assessment of need addressed?
- Dressing disruptions?
- Proper injection ports placed (Tego for dialysis lines)?
- Mechanical problems with line?
- Patient risk factors?
<table>
<thead>
<tr>
<th>Brief Summary:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Line properties (site, #lumens, temp vs. perm.):</th>
<th>Line present on admission? If so, what, if any evaluation was done of the line?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Was line placement Emergent?</th>
<th>Indication for central line:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Line Insertion (hand hygiene, skin prep, barriers used, # attempts, date/time, inserter):</th>
<th>Was CHG-impregnated patch used? If so, when was it first noted in EPIC?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Was line removed as soon as possible?</th>
<th>When was the order placed to remove the central line? When was the order acknowledged and documented as completed?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Any inappropriate line access? (i.e. inappropriate staff, blood draw, etc.)</th>
<th>Was line necessity evaluated daily?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Any signs of infection at the central line site?</th>
<th>Any dressing disruptions noted?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Were any mechanical problems noted with the CYC?</th>
<th>Are there any significant patient factors that may have contributed to this infection?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Were there any noted deviations from appropriate line access and maintenance?</th>
<th>Was this infection potentially preventable?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Meeting Discussion:</th>
<th>Action Items:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>


<table>
<thead>
<tr>
<th>Date</th>
<th>T-</th>
<th>HR/Note</th>
<th>WBC</th>
<th>Line(s) (per Doc Flowsheet)</th>
<th>CVG Day #</th>
<th>RM Central Line Site Assess AM/PM</th>
<th>RM Central Line Dressing Assess AM/PM</th>
<th>MD Notes</th>
<th>Procedures</th>
<th>Misc.</th>
</tr>
</thead>
<tbody>
<tr>
<td>AM:</td>
<td>PM:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>AM:</td>
<td>PM:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>AM:</td>
<td>PM:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>AM:</td>
<td>PM:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>AM:</td>
<td>PM:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>AM:</td>
<td>PM:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>AM:</td>
<td>PM:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>AM:</td>
<td>PM:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>AM:</td>
<td>PM:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>AM:</td>
<td>PM:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>AM:</td>
<td>PM:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>AM:</td>
<td>PM:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>AM:</td>
<td>PM:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>AM:</td>
<td>PM:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>AM:</td>
<td>PM:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>AM:</td>
<td>PM:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>AM:</td>
<td>PM:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>AM:</td>
<td>PM:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>AM:</td>
<td>PM:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>AM:</td>
<td>PM:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
What was likely reason for infection and could this have been avoided?

• Attempt to determine cause
• Determine actions to address issues found
• Reinforce best practices
• Report findings to stake holders, Quality Board
• Need to now take next step to measure the interventions made due to findings. Have official action plans with owners of the items.
Reactions from Clinicians

• Very reluctant at first but always walk out with new revelations and ideas for prevention. It is hard to get them there.

• Quote from ED MD: “I’m making sure all the sterile barriers are used and skin prep is correct. I don’t want infections and I don’t want to report for a case review.”
Pitfalls & Barriers

**Barriers**
- Difficult to get team together who cared for the patient
- Skepticism on the value of the meeting
- Defensiveness
- Worried about blame

**Pitfalls**
- Blame the patient
- “The patient was so sick infection was unavoidable”
- “The infection was there when they came in”
- “The infection came from other site”
Success

• Stake holders including the physicians are attending the case reviews
• All seem to be engaged in what contributed to infection and what could have been done to prevent
• Reinforced best practices: groin prep scrub times, removal of lines, addressing lines on rounds, documentation, Biopatch, Tego connectors
• Genuine thankfulness from clinicians that the case review was called
Plan for the Future

• Continue to do real time case reviews for each CLABSI

• Use review learnings for actionable interventions. Develop action plans and owners of the interventions.

• Hope is: central line insertion, maintenance, and removal will be perfect thus eliminating need for real time case reviews!
CAUTI

Linell Santella, Infection Prevention & Control
Case Review of CAUTI HAIs

Infection Preventionist (IP) completes line list, describing

a. How HAI meets NHSN definition for CAUTI
b. Indication for urinary catheter insertion
c. Where/who inserted catheter
d. Documentation of daily catheter care
e. Bladder scanner usage
# CAUTI Investigation Line List

<table>
<thead>
<tr>
<th>Month</th>
<th>Attributed Unit</th>
<th>Last Name</th>
<th>BMI (kg)</th>
<th>MR#</th>
<th>Age</th>
<th>Primary Diagnosis</th>
<th>Admit Date</th>
<th>Foley removed before cx obtained?</th>
<th>Cx obtained due to appearance/odor of urine</th>
<th>Culture date</th>
<th>Vent?</th>
<th># of vent days before pos. cx</th>
<th>Organism</th>
</tr>
</thead>
<tbody>
<tr>
<td>Foley Insertion Date</td>
<td>Location of foley insertion (dept, unit)</td>
<td>Rectal tube</td>
<td>Initial indication for insertion of foley</td>
<td>Name of individual inserting foley</td>
<td>Foley removal date</td>
<td>Total Foley Days</td>
<td>Initial foley indication not appropriate based on chart review (Y or N)</td>
<td>Daily catheter care documented (Y or N)</td>
<td>Is there an order for the Foley?</td>
<td>How many times was the bladder scanner used prior to insertion?</td>
<td>How did patient meet definition of CAUTI?</td>
<td>Outcome</td>
<td></td>
</tr>
</tbody>
</table>


HAI Communication

Line list emailed to unit leaders/ CNS/ Educator

CNS / Educator reviews case with unit-based quality team nurses, identifying contributing factors

Findings / Learnings shared with nursing staff
<table>
<thead>
<tr>
<th>On the CUSP: CAUTI Alert</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Situation</strong></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td><strong>Background</strong></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td><strong>Assessment</strong></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td><strong>Recommendations</strong></td>
</tr>
<tr>
<td></td>
</tr>
</tbody>
</table>
Example – how one issue was addressed

• All patients having Colon procedures are located on one nursing unit
• Colon patients get epidurals so have foleys placed
• Foleys left in at least until epidural removed, some times up to 7 days later
• No reduction in foley utilization
• Surgeons want proof of no patient harm with practice changes
The Plan

• With surgeon support, 6 month trial – revised post-op orders to include removal of foley by POD 1 in patients with epidurals
  ➢ Tracked data: foley days; epidural removal; bladder scanning; reinsertion of foley; CAUTIs

• Reinforced use of bladder scanner protocol before straight cathing or reinsertion of foley
Lessons Learned

• When clinical judgment requires foley be left in longer, if SCIP measures are understood, surgeon will comply with appropriate documentation.

• Nursing must speak up for patient safety rather than convenience.

• Early removal of foley did not result in bad outcomes—retention not excessive; infrequent reinsertion of foley.
Improvements Made

• Removal of foley on POD 1 of patients with epidurals is now a permanent order
• Nursing more comfortable with bladder scanner protocol
• Foley utilization is going down
• Risk of CAUTI is down – zero CAUTIs x 5 months
Using a Modified Root Cause Analysis for C. difficile Reduction

Jessica Nerby, MPH, CLS, CIC
Manager, Infection Prevention and Control
Abbott Northwestern Hospital, Part of Allina Health
Root Cause Analysis

• What happened, why it happened, how can it be prevented
• Team includes front line staff and individuals familiar with the situation, leaders
RCA for C diff ANW

ANW Hospital Acquired Lab ID Rate

Rate per 10,000 pt-day

1Q10  2Q10  3Q10  4Q10  1Q11  2Q11  3Q11  4Q11  1Q12  2Q12  3Q12  4Q12  1Q13  2Q13  3Q13  4Q13  1Q14  2Q14
Hospital Acquired Clostridium difficile After Action Review and Plan

Managers—please use this form to generate discussion among the staff that cared for the patient from the time of admit to the date of positive C diff test result. The questions below are all potential risk factors for C. diff transmission. The goal of this after action review is to review staff practice around C diff patients and to identify any gaps in practice or PPE availability that may have contributed to transmission. Please complete the questions/review in the appropriate sections and return back to Jessica Nerby in Infection Prevention (internal zip 16400 or e-mail Jessica.nerby@allina.com).

Date of Positive Test Result:

Patient bed trace:

The Patient:

The Patient’s Course

Hand hygiene and precaution compliance:

Review questions for inpatient units:

1) Review the data on the unit compliance with hand hygiene and precaution compliance—what can you do to improve the rates?
2) Review your standard process for cleaning on the unit:
   a. Are keyboards and phones at the nursing station disinfected at least once per shift?
   b. Does equipment coming out of Contact and Enteric precaution patient rooms get wiped with disinfectant before being used on another patient or being placed in the soiled utility room?
   c. Are supplies routinely disinfected or discarded with a C. difficile patient discharges?
   d. Are there any equipment in the patient room that is kept in cupboards of shelves and thus may be missed by environmental services and unit staff during discharge cleans?
3) Please review the questions below if there were other Enteric Precautions patients on the unit while the patient listed above was on the unit.
a. Were bleach wipes available for the Enteric Precaution patients?
b. Are sinks readily available outside of the Enteric Precaution patient room?
c. Was the Enteric Precaution sign posted?
d. Were gown and gloves routinely available?
e. Did all equipment leaving the patient room get cleaned with bleach?
f. Did supplies get discarded or cleaned with bleach when the patient discharged?

If any Process Improvement is required to correct deficiencies or eliminate gaps in process please use the following table to list intervention, timeline, and responsibilities:

<table>
<thead>
<tr>
<th>Area For Improvement</th>
<th>Task(s) needed to support improvement</th>
<th>Due Date</th>
<th>Assigned To</th>
<th>Summary/Result</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Review questions for Environmental service staff:**

1. Have EVS daily and terminal room cleans been done using bleach for all Enteric Precaution patients in the hospital?
2. Has Xenex been deployed to all Enteric Precaution patient discharges?
3. Please review the questions below if there were other Enteric Precautions patients on the unit while the patient listed above was on the unit.
   a. Are sinks readily available outside of the Enteric Precaution patient room?
   b. Was the Enteric Precaution sign posted?
   c. Were gown and gloves routinely available?
   d. Were daily and terminal rooms cleans done with bleach?
   e. Were gown and gloves worn to clean Enteric Precaution patient rooms?
If any Process Improvement is required to correct deficiencies or eliminate gaps in process please use the follow table to list intervention, timeline, and responsibilities:

<table>
<thead>
<tr>
<th>Area For Improvement</th>
<th>Task(s) needed to support improvement</th>
<th>Due Date</th>
<th>Assigned To</th>
<th>Summary/Result</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Review questions for RT/PT/OT, social work, radiology, nutrition/dietary, patient transport:**

1. Review the data on the compliance with hand hygiene and precaution compliance – what can you do to improve the rates?
2. Review your standard process for cleaning:
   a. Does equipment coming out of Contact and Enteric precaution patient rooms get wiped with disinfectant before being used on another patient or being place in the soiled utility room?
   b. Are there any equipment in the patient room that is kept in cupboards of shelves and thus may be missed by environmental services and unit staff during discharge cleans (e.g. patient transfer belts)?
3. Please review the questions below regarding other Enteric Precautions patients you may have seen:
   a. Were bleach wipes available for the Enteric Precaution patients?
   b. Are sinks readily available outside of the Enteric Precaution patient room?
   c. Was the Enteric Precaution sign posted?
   d. Were gown and gloves routinely available?
   e. Did you wear gown and glove for all room entries?
   f. Did all equipment leaving the patient room get cleaned with bleach?
   g. Did supplies get discarded or cleaned with bleach when the patient discharged?
<table>
<thead>
<tr>
<th>Area For Review</th>
<th>Improvement Needed?</th>
<th>Task(s) needed to support improvement</th>
<th>Due Date</th>
<th>Assigned To</th>
<th>Summary/Result</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Unit hand hygiene and enteric precaution compliance</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Was patient placed in Contact Precautions as soon as C. difficile suspected? Changed to Enteric when test positive?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Was patient on an H2 blocker or PPIs? Were they indicated?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Was patient on antibiotics? Were they indicated?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Area For Review</td>
<td>Improvement Needed?</td>
<td>Task(s) needed to support improvement</td>
<td>Due Date</td>
<td>Assigned To</td>
<td>Summary/Result</td>
</tr>
<tr>
<td>-----------------</td>
<td>---------------------</td>
<td>--------------------------------------</td>
<td>----------</td>
<td>-------------</td>
<td>----------------</td>
</tr>
<tr>
<td>5. Were bleach wipes available and used?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. Were items coming out of enteric precaution room cleaned with bleach?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. Were EVS daily and terminal room cleans done using bleach?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8. Was Enteric Precaution sign posted?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9. Were gown and gloves available?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10. Was patient given education on enteric precautions and C. diff – was it documented in Excellian?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>11. Was hand hygiene done with soap and water after leaving Enteric Precaution patient rooms?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>12. Are hand washing sinks readily available near Enteric Precaution patient room?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Results

• Identified many gaps in practice and product availability on the units and in ancillary departments
  – Bleach wipe placement
  – Developing signage regarding hand washing

• Increased unit staff and leadership engagement in infection prevention activities

• Reduction in number of pseudo-outbreaks/clusters (10→3) and decrease in HA C diff infections
ANW: Hospital Acquired Clostridium difficile After Action Review and Plan

Managers please use this form to generate discussion among the staff that cared for the patient from the time of admit to the date of positive C diff test result. The questions below are all potential risk factors for C. diff transmission. The goal of this after action review is to review staff practice around C diff patients and to identify any gaps in practice or PPE availability that may have contributed to transmission and develop processes to eliminate those gaps. The questions are there to help generate discussion but you are not required to return the form to infection prevention unless you would like to enlist infection prevention assistance with any issues discovered during the discussion with your staff.

Date of Positive Test Result: 8/27/12

Patient bed trace:

The patient:
The Patient’s Course:

Patient antibiotics during hospitalization:

FFI/H2 blocker use:

Hand hygiene and precaution compliance:

Exposure to other C. difficile patients:

Unit hospital-acquired C. difficile rates

Review questions for discussion (not all will be appropriate for your staff):

1. Review the data on the unit compliance with hand hygiene and precaution compliance – what can you do to improve the rates?
2. Review your standard process for cleaning on the unit:
   a. Are keyboards and phones at the nursing station disinfected at least once per shift?
   b. Does equipment coming out of Contact and Enteric precaution patient rooms get wiped with disinfectant before being used on another patient or being place in the soiled utility room?
   c. Are supplies routinely disinfected or discarded with a C. difficile patient discharge?
   d. Is there any equipment in the patient room that is kept in cupboards of shelves and thus may be missed by environmental services and unit staff during discharge clean?
3. Please review the questions below if there were other Enteric Precautions patients on the unit while the patient listed above was on the unit
   a. Were bleach wipes available for the Enteric Precaution patients?
   b. Are sinks readily available outside of the Enteric Precaution patient room?
   c. Was the Enteric Precaution sign posted?
   d. Were gowns and gloves routinely available?
   e. Did all equipment leaving the patient room get cleaned with bleach?
   f. Did supplies get discarded or cleaned with bleach when the patient discharged?
   g. Did the room receive a Xenex treatment after terminal room clean
4. For the current C. diff patient:
   a. Did Enteric precautions get ordered in Excelian?
   b. Was the patient/patient family given information on C. difficile and Enteric Precautions?
HAND WASHING

Because C.diff Tastes Even Worse Than It Smells