Dare To…. Defy C Diff

Lourdes C. Fernandez RN, BSN, CCRN, CSC
Lehigh Valley Health Network, Lourdes_C.Fernandez@lvhn.org

Roslyn M. Harris MS, BSN, RN, CCRN-CMC
Lehigh Valley Health Network, Roslyn_M.Harris@lvhn.org

Follow this and additional works at: http://scholarlyworks.lvhn.org/patient-care-services-nursing

Part of the Nursing Commons

Published In/Presented At

This Poster is brought to you for free and open access by LVHN Scholarly Works. It has been accepted for inclusion in LVHN Scholarly Works by an authorized administrator. For more information, please contact LibraryServices@lvhn.org.
Lehigh Valley Health Network, Allentown, Pennsylvania

Lourdes C. Fernandez BSN, RN, CCRN-GSC and Roslyn M. Harris, MS, BSN, RN, CCRN-CMC, Staff Members of the Intensive Care Unit /Regional Heart Center Surgical

**Project Goal**
Implement a compendium of evidence-based preventive measures to decrease the *C. difficile* infection (CDI) rate in a 20-bed medical-surgical intensive care unit (ICU) in an academic, community Magnet™ hospital.

**Significance**
Over the past decade, the incidence of CDI in the acute health care setting has increased substantially, with the critical care patient at especially high risk.

**Evidence**
- Sources: Centers for Disease Control, Association for Professionals in Infection Control and Society for Healthcare Epidemiology of America
- Recommendations
  - Isolation supply caddies stocked with Personal Protective Equipment
  - Bleach wipes
  - Stool Culture Protocol
  - Contact signage
  - Ultraviolet C irradiation for terminal cleaning

**Evidenced-Based Solutions & Actions**
Recognizing that expert knowledge, in conjunction with research, supports evidence-based practice, the LVHN ICU nurses enhanced standard guidelines with additional measures:
- Utilization of disposable bedside cardiac monitoring leads
- Monitoring for diligent terminal room cleaning, i.e. changing privacy curtains
- Use of fecal containment systems
- Posting additional signage
- Emphasis on staff and visitor education
- Limiting supplies in the room
- Disposing all supplies upon discharge
- Peer accountability

**Strategies for Success**
- Staff engagement through shared governance
- Visibility
- Ongoing momentum supported by:
  - Weekly newsletter with gentle reminders of standards and real-time data
- Incentivized annual goals tied to the staff performance appraisal

**Implication for Practice**
Preventive measures for CDI can be perceived as daunting by critical care nurses, who recognize the alarming mortality rates associated with CDI in their compromised patients. The efforts in this ICU can serve as a pragmatic model which can be replicated by critical nurses in a variety of settings to prevent CDI.

**Outcomes**

*Clostridium difficile* Intensive Care Unit
Infection Rate Per 1,000 Patient Days

Because there are no national benchmark data available for CDI rates in designated acute care, inpatient settings, it is recommended an internal historical comparison be used to track rates.