The Scat on C. diff: Reaching Zero Infections

Gianna Peralta
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**Background**
Historically, the rate of hospital-onset (HO) C. difficile infections (CDI) has been higher than expected at Queen of the Valley Medical Center (QVMC). Recognizing that current prevention efforts were not successful in achieving the dramatic reduction needed, Infection Prevention established a multidisciplinary team to review current practices and implement evidence-based prevention efforts based on current literature and guidelines.

**Project Aim**
To establish the C. diff Collaborative Task Force, comprised of Infection Prevention, a physician champion, infectious disease physician, nursing leadership, pharmacy, and environmental services. The team conducted a root cause analysis (RCA) for all HO CDI and developed tools and education for improvement. Primary goals included: 1) prompt identification and isolation of patients with suspected C. diff and, 2) timely and appropriate treatment.

**Outcomes**
Queen of the Valley has achieved steady reduction of the number of hospital-onset CDI:
- 2016: 31 HO cases
- 2017: 29 HO cases
- 2018: 15 HO cases
- 2019: 11 HO cases

Additionally, there were three months in 2018 with zero identified HO CDI infections. So far in 2019 (Jan-Sept), there have been two months with zero identified HO CDI infections.

**Tools and Resources**
- Testing and treatment guidelines for providers
- Defined criteria for patients at high risk of developing C. diff
- Ambulation guidelines for patients on enteric isolation precautions
- Testing decision tree
- Infection prevention bundle for C. diff
- Testing audit tool
- Revised testing algorithm
- Weekly report at leadership huddle to facilitate nursing and EVS communication

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**Graphs and Tables**
- Hospital-onset C. difficile Infections 2019 versus 2018
- St. Joseph Hospital Northern California: Queens Medical Center
- Queen of the Valley Medical Center
- Hospital-Acquired C. difficile infection
- Standardized Infection Ratio (SIR)
- Infection prevention bundle for C. diff
- Testing decision tree
- Infection prevention bundle for C. diff
- Weekly report at leadership huddle to facilitate nursing and EVS communication

**Lessons Learned**
- Need support from leadership, action driven by frontline staff
- Early identification of appropriate patient population
- Prompt treatment of patients meeting criteria for testing
- Education needed on interpretation of PCR and toxin test results
- Strict standards for testing only unformed stools
- Novel physician champion and infectious disease support
- Repetition is key, tailor education for intended audience