PURPOSE:
To assess the safety and quality of patient care provided by establishing a baseline at each agency, to monitor trends within the agency, to use findings to improve care, and to prevent healthcare associated infection (HAI) and other complications.

CONSIDERATIONS:
1. HAI definitions for the purpose of surveillance must be established.
2. Definitions must be consistently used in the collection, analysis and reporting of infection data.
3. Surveillance definitions are not intended to be used to make clinical decisions.
4. Surveillance definitions for homecare and hospice have been developed and published by the Association for Professionals in Infection Control and Epidemiology (APIC) – HICPAC: Surveillance Definitions for Home Health Care and Home Hospice Infections, 2008.
5. A risk assessment of the population served, range of services, and historic infection data must be performed each year to identify process and outcome surveillance.
6. Data collectors should be trained in the written definitions adopted by the agency.
7. Access to consultation with a hospital Infection Preventionist (IP) or other IP resource may be beneficial.
8. Data must be analyzed and interpreted.
9. Numerator data (number of infections) may detect problems but infection rates should be calculated to monitor meaningful trends.
10. Data sources include, but are not limited to, agency staff, physicians, hospital records, laboratory results and antibiotic orders for other than prophylaxis.
11. HAI surveillance can be assessed with both process and outcome measures.
12. Process objectives may include, but are not limited to:
   a. Adherence to published standards, conditions and/or recommendations from accrediting bodies, regulatory agencies and third party payors.
   b. Compliance with hand hygiene practices, provision of recommended immunizations, and management of invasive medical devices (e.g., insertion, maintenance, and securement of catheters) by agency personnel.
   c. Appropriateness of medical device use and possibly of antimicrobial therapy.
   d. Training and competence of care provided by family or other members of the patient’s support system in the home.
   e. Evaluation of specific infection prevention and control measures.
   f. Impact of education and training to patient and healthcare givers.
   g. Identification and reporting healthcare associated infections back to the facility (i.e., hospital, ambulatory surgical centers, long term care facility, etc.) where the patient received the care.
   h. Identification of possible trends, outbreaks or newly emergent infectious diseases in the community.
13. Outcome measures should focus on those outcomes associated with processes of care provided by the agency personnel such as device-associated infections. Outcome objectives may include, but are not limited to:
   a. Vascular access device infections.
   b. Central line associated blood stream infection and local cannula infection.
   c. Peripheral line associated infection.
   d. Catheter associated urinary tract infection.
   e. Skin and soft tissue infection.
   Include reductions in morbidity, mortality, emergency care and acute care hospitalizations and cost.
14. Describing an infection as homecare or hospice healthcare-associated does not necessarily indicate that the infection was caused by the home health or hospice staff.

EQUIPMENT:
1. The following equipment is helpful to have available:
   a. Computer with email and Internet capacity program for recording data
   b. Phone for IP networking
   c. Tools for staff reporting such as: blank calendar sheet for each month in which staff enters name of patient, antibiotic ordered and reason for antibiotic. May use a form designed by the agency for infection reporting.

PROCEDURE:
1. Clinicians report potential infections to the IP or data collectors assigned by the agency.
2. IP or data collectors review hospital records, laboratory results, etc. to identify potential HAI.
3. Potential infections are reviewed by the IP to determine if the infection meets the surveillance definition for infection.
4. A line listing of infections is completed each month.
5. Rates are calculated either as:
   a. Per patient days (# infections/patient days x 1,000)
   b. Device days (# infections/device days x 1,000)
6. Data is compiled and reviewed on a regular basis (monthly or quarterly) by the IP looking for trends and potential problems.
AFTER CARE:

1. Surveillance data is distributed to healthcare workers and administrative team, as appropriate.
2. Negative trends are identified and a response plan developed and implemented.
3. Policies and procedures development or revision occurs whenever surveillance data provides opportunity for improvement.
4. Staff education occurs as surveillance trends indicate need; new or revised procedures occur.
5. HAIs are reported to external organizations as indicated.

REFERENCES:


Special Communication Requirements for infrastructure and essential activities of infection control and epidemiology in out-of-hospital settings: A Consensus Panel Report SHEA and APIC 1999 Note this resource does not include Hospice and only includes device related infections in Home Care

The Joint Commission