



University of Connecticut Health Center  
*John Dempsey Hospital*

April 24, 2014

Richard Melchreit, MD  
Healthcare Associated Infections Program Coordinator  
Connecticut Department of Public Health

Dear Dr. Melchreit:

John Dempsey Hospital (JDH) welcomes the State of Connecticut's public reporting of hospital acquired infections. We believe that this transparency of outcomes will help drive performance improvement initiatives across the state that will decrease hospital length of stay, decrease hospital costs, and most importantly, save lives. JDH has had a long-standing infection prevention program that monitors infection occurrences throughout our hospital. Current initiatives have focused on hand hygiene, central-line associated bloodstream infections (CLABSI), catheter-associated urinary tract infections (CAUTI), and surgical site infections (SSI). All staff participate in annual infection prevention training and, through participation with a collaborative with the Connecticut Hospital Association, receive training in techniques of patient safety and high reliability.

Specific to CLABSI, our performance improvement initiatives have resulted in adoption of best practices that include using a standardized checklist for line insertion, standardized line insertion carts and kits, nursing presence during line insertion to monitor sterile technique, full barrier precautions with insertion, and daily goals sheets that emphasize early removal of central lines. The care of central lines has also improved with the *Scrub the Hub* program (use of chlorhexidine wipes to clean the ports), peripheral preference for routine lab draws and cultures (limiting the amount of times the central line is accessed, standard dressing changes supplemented with daily nursing rounds to monitor the line insertion site and most recently, adoption of chlorhexidine bathing in the ICU). If an infection does occur, there is a mini-root cause analysis performed and the findings reviewed with the bedside staff and the Infection Control Committee for identification of opportunities for improvement. These changes have involved a multidisciplinary team as part of the national Comprehensive Unit-based Safety Program (CUSP). Their work has resulted in dramatic and sustained improvement in the CLABSI rate such that at the time of this letter, it has been 439 days since the last CLABSI in our intensive care unit. Our goal is to now maintain our zero event rate.

Regarding Surgical Site Infections, we have a team that has begun implementing changes to reduce the infection rate. These changes begin when the patient is seen in the ambulatory Surgery Clinic such as improved pre-operative teaching and chlorhexidine washing, include adopting intraoperative best practices for wound closure and body temperature management, and involve modifications to post-operative wound management.

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For CAUTI, we implemented a pilot program as part of the CUSP initiative that has now extended to all inpatient units involving education to ordering providers and nursing on guidelines for the indications of the use of an indwelling urinary bladder catheter and the importance of early catheter removal. The Infection Prevention team monitors urinary catheter usage and provides feedback to each hospital unit. A new initiative will be focusing on the technique of urine sample collection that will include reeducation on best practices for urinary catheter insertion.

Patient safety is top priority at John Dempsey Hospital and UCONN Health. We are committed to performance improvement in an effort to achieve a zero event rate for all hospital-acquired infections.

Sincerely,



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