Type: Poster Presentation

How fast we are? Consultation of and from infectious diseases department, a retrospective observational study

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Background: Because of the antibiotic policy in Turkey,most of the IV antibiotic usage is restricted to signed confirmation of infectious diseases(ID) specialist.The number of the consultations has been high because of this policy. Here we tried to detect the technical details of consultations of and from ID department in a atertiary care hospital.

Methods & Materials: The study was held in a tertiary care hospital in Ankara,Turkey,between September and December 2013.Two branches were planned to run the study,in one branch the ID consultations to other clinics for 100 patients evaluated while in the second branch the consultation demands from other clinics to our ID in-patients for a 3 months period evaluated retrospectively.The time(in hours) from the demand of the consultation(DC) to seeing and closing/signing of the demand after seeing each patient was defined as consultation time(CT).

Results: *ID consultations to other departments*

The goal of a total of 100 patients'consultations was achieved within three days.The mean of CT was 1.8 hours(min1 max 8 hours);70% of the all patients were seen by our ID consultant within one hour of DC.Of all,21 DC was just for the signed confirmation of an antibiotic which was already started by the owner clinic.In 68(68%) consultations a new antibiotic was started or a dose adjustment was made.In 90(90%) patients the clinics obey our suggestions like taking blood culture.Only 17 patients(17%) had culture results prior to ID consultation.Re-consultation by our ID department was needed for 8(8%) patients.

Consultation demand from other clinics to ID patients

Table 1
Consultation demand from other clinics to IO patients (n=72 patients)

Consultation umber for each patient, n, median (min-max)	5(1-24)
Total number of the Consultations, n	278
Consultations from internal departments[*], n(%)	195 (70.1)
Consultation time, hours, mean (min-max)	3.2 (1-12)
Consultations from surgical departments[**], n(%)	83 (29.9)
Consultation time, hours, mean (min-max)	3.5 (1-8)
Need for a surgical intervention, n(%)	10 (13.9)
Need for a re-consultation, n(%)	53 (73.6)
Reasons for re-consultation, n(%)	
Not coming to first demant	3 (5.7)
Because of new laboratory results	32 (60.4)
Inadequate response or patient was changed for the worse	18 (33.9)

[*] Internal departments: Internal medicine, pulmonology, cardiology, dermatology,neurology, psychiatry
[**] Surgical departments: Cardiovascular surgery,general surgery, orthopedics, urology, gyneacology, neurosurgery, ophtalmology, otorhinolaryngology, plastics and reconstructive surgery

Seventy-two in-patients were followed in ID department within three months.The median of hospitalization was 10(2-21) days.A total of 278 consultations from different departments were asked.The details were given in Table 1.

Conclusion: It seems that the ID consultant is working faster.Re-consultation need was 8% for an ID consultant while it was 74% for other departments,the ID consultant closes the file more efficiently or the ID inpatients are severe patients who need many consultations from other departments?The issue is needed to be explained with further studies.

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Multiple approaches to decrease the rate of MDROs colonization in intensive care unit at tertiary care hospital in Saudi Arabia

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Background: MDROs infections can cause serious diseases and mortalities, and colonized or infected patients may serve as reservoirs and lead to outbreaks. The mean rate of MDROs colonization was 1.73/1000 patients days in 2011 and increased progressively to 9.35/1000 patients days in 2012 with a peak of 18.85/1000 patients days in November 2012. We planned to decrease the rate of colonization by 75% in 2013. Therefore a quality improvement initiative group by the Infection Control Department (ICD), Nursing and Housekeeping was launched to implement the environmental hygiene stewardship program.

Methods & Materials: The initiative group used a quality improvement model called FOCUS–PDCA. A root cause analysis was done to identify the issues behind the increased rate of MDROs colonization. The rate was 18.85/1000 patients days in November 2012 and this was considerably high due to low of compliance with isolation guidelines and hand hygiene, new untrained housekeeping staff, the use of low level surface disinfectants with shortage of cleaning materials, lack of regular monitoring process for cleaning and disinfection and shortage in isolation rooms. During December 2012, the interventions were implemented which include extensive infection control education for all healthcare workers and housekeeping staff, hand hygiene improvement campaign, provide enough cleaning materials, use broad spectrum disinfectant (Hydrogen Peroxide with silver stabilizer), management of isolation rooms and monitoring the effectiveness of the cleaning process by using Clean-Trace Surface Protein (Allergen) test. The (ICD) continued to screen and culture all patients in the MSICU for colonization on weekly basis to detect any new cases of MDROs colonization.

Results: The multi-approach intervention was very effective in reducing MDROs colonization rates. The rate was 9.35/1000 patients days in 2012 (before the intervention) and decreased to 2.11/1000 patient days in 9 months in 2013 (after the intervention). The project had achieved a 77.5% reduction than we planned for.

Conclusion: Environmental Hygiene Stewardship program as a multi approach and comprehensive package of interventions that incorporated advanced cleaning technology, health education for