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Workshop B:

How healthcare characteristics influence antimicrobial resistance and healthcare associated infections.

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Characteristics of healthcare systems

- EU member states: different healthcare systems but all have high levels of government responsibility and are mostly publicly financed.
- "Paying for quantity is easier (to handle) than paying for quality"
- Incentive – productivity but with a ceiling; difficult to capture quality.

Feedbacks and risks of health care parameters potentially influencing the occurrence of AMR and HCAI

- Central leadership and central strategies on patient safety, including HCAI and AMR.
- Prevention and control is cost effective but that does not mean that prevention measures will be automatically implemented by those governing.
- **Promotion of patient safety programs should be accompanied by financial incentives for prevention, at least avoid dis-incentives.**

Drug policy parameters influencing antibiotic usage in hospital setting

- The use of medicine is driven by many factors
 - traditions, habits, social and cultural factors, economic factors, authority, role models, scientific information, infrastructure, workload & staffing, drug industry.
- The use and misuse of antimicrobials drive antimicrobial resistance.
- The fear of resistance (justified or perceived) leads doctors to use more potent drugs (2nd or 3rd line antibiotics); these drugs are 2 to 90 times costlier than the first-line drugs, and further drive resistance.
- There is a controlled and an uncontrolled market (for example via Internet). Uncontrolled markets represent a potential risk for distributing substandard medicines to European patients. The size of this problem should be investigated.

Microbiological laboratory capacity – threats and opportunities with current trends 1

- **Medical microbiology** is more than just a laboratory exercise. It is the analysis of a sample, the synthesis of results and the clinical consultation. These form the basis for infection control and surveillance of antimicrobial resistance.
- **Medical microbiology** is since 2008 in Europe a recognized medical specialty by UEMS. However, many countries report an increasing shortage of medical microbiologists. This must be remedied.
- **Concentration** of resources and volumes is good, but only up to a limit.
- **Outsourcing** of microbiological analysis separates the analysis (of the sample) from the process of synthesis and consultation. It leaves antimicrobial resistance surveillance and infection control adrift.

Microbiological laboratory capacity – threats and opportunities with current trends 2

- **Amalgamation** of clinical microbiology into large general laboratory services is a threat in the absence of **microbiological leadership**. Successful "big labs" separate administrative/economic overall leadership from medical leadership of respective specialty.
- **Automation** contributes to quality and standardiation of antimicrobial susceptibility testing in Europe. **But there is a temptation to consider it too "automatic"**.
- **Accreditation** contributes to quality and standardisation of antimicrobial susceptibility testing in Europe. **But only on a technical level.**

Intensive care 1

- **Infection control is paramount.** Any reduction in the number of HCAI will reduce the burden of resistant bacteria.
- The introduction of **easily accessible alcohol rub** is extremely cost effective.
Changing cultural behaviour and measuring compliance are essential and cheap but require hard work and dedication.
- **Understaffing** and **overcrowding** must be avoided. Optimal staffing ratios must be looked into.
- **Isolation capacity** - single rooms or at a minimum enough space between beds.
- Competent advice must be sought when building **new facilities**.

Intensive care 2

- Intensive care should be better standardized across Europe.
- INTENSIVE CARE needs recognition as a specialty.
- There is room for improvement of multi-disciplinary collaboration.
- Reimbursement mechanisms should be looked into. It is most probably detrimental to reimburse on DRG rather than “good practice”.
But – how to incentivize good practice?

Infection control (hygienic precautions): surveillance 1

- Approximately 30 % of HCAI can be prevented.
- **Surveillance in itself contributes to prevention of HCAI.**

Models for surveillance:

- HCAI incidence and/or prevalence
- alert organisms
- cluster warning
- indicators for procedures (hand hygiene, alcohol rub consumption)
- indicators for HCAI outcome
- indicators for structure & process

Infection control (hygienic precautions): surveillance 2

- **Conditions and Barriers**
 - Hospital level
 - multidisciplinary teams,
 - support from management
 - create systems for surveillance
 - National level
 - national programmes directed at HCAI
 - support and backup for hospital activities
 - guidelines for surveillance
 - EU level
 - Provide methodology and support
 - Provide guidance and recommendations

Infection control (hygienic precautions): local organisation

- Structure
- **Adequate infection control (IC) staff**
 - Research needed to determine adequate IC nurse/No. of beds and IC MD/No. of beds and other factors influencing this ratio.
 - Trained and dedicated
- National programmes for training of IC practitioners.
- National objectives and goals are needed.
- Systems for regional and national quality control of IC.

Barriers: motivation, structural, budgetary, political (national and local)

Experts say: "Infection control is an investment which always pays its own cost". But are we sometimes running financial systems that act as a dis-incentive for infection control?"

Infection control (hygienic precautions): role of public health authorities

- Member states should have **multi-disciplinary national committees** with agreed objectives in place. BUT this is not always the case.
- Are international comparisons of national data powerful agents of change?
- Does the use of punishment strategies threaten continuous quality improvement?
- Should patient pressure groups (and the media) be encouraged to get involved to an even higher degree?

Publication of hospital specific HAI infection rates

Is it useful to publish hospital rates of infection, or process/structural indicators?

Different possible strategies:

- Confidential within the health care institution.
- Confidential within surveillance networks with publication of anonymous (aggregated) results (e.g. surveillance of surgical site infections).
- Disclosure to public health authorities e.g. early warning of notifiable nosocomial events.
- Public reporting of agreed indicators.

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