Part 1: Diagnostic Stewardship Leading to Antimicrobial Stewardship & Quality Patient Outcomes

Wednesday, July 6 3 - 4 p.m. ET  Register HERE

Target audience: Quality, Infection Prevention, Pharmacy, Antimicrobial Stewardship, Laboratory and Microbiology teams

In September 2021, a CDC report found that hospital-acquired infections had increased significantly in 2020 after years of steady decline. Standard infection prevention practices have been impacted by staffing shortages and chaotic work environments, which has subsequently created an environment that is susceptible for diagnostic errors. These factors indicate a troubling trend working against antimicrobial and diagnostic stewardship efforts.

As a result, hospital and healthcare system leaders are re-focusing their attention on patient safety and quality outcomes—and trying to solve the problems of blood culture contamination, which can lead to a misdiagnosis of sepsis. With those goals in mind, we will focus on practical and effective solutions designed to reduce the risk of antibiotic-related infections, antimicrobial resistance, and false-positive blood cultures.

Part 2: Mitigation of False-positive CLABSIs & Emerging Technologies

Tuesday, July 19 3 – 4 p.m. ET  Register HERE

Target audience: Quality, Infection Prevention, Pharmacy, Antimicrobial Stewardship, Laboratory and Microbiology teams

A central line blood stream infection (CLABSI) is a serious infection that occurs when bacteria or other organisms enter the patient’s central line and then enter their bloodstream. These serious infections are associated with increased morbidity, mortality, and health care costs. In 2020, the target was for CLABSI rates to improve by 50% compared to the 2015 baseline. However, during COVID-19, the national SIR for CLABSI increased 46% during Q3 & Q4 of 2020, compared to the same period in 2019.

This webinar is designed to assist hospitals in implementing and prioritizing their CLABSI prevention efforts through diagnostic and antimicrobial stewardship, improved quality patient outcomes and optimized CMS reimbursement. We will further review the link between blood culture contamination and CLABSI incidence and discuss comprehensive recommendations for defining, detecting, and mitigating HAIs and false-positive CLABSIs.

Joining IHA in this discussion will be Tammy Johnson, Magnolia Medical Technologies and Quality Improvement Advisor & Infection Prevention Champion, Barb DeBaun