The New York State Department of Health (NYSDOH) flagged the organization for having high rates of hospital-onset CDI. The hospital responded to this by developing Best Practice Alerts (BPA) to help track the changes and determine whether further action would be necessary.

The team decided to use evidence-based practice to reduce time to identify, treat, and isolate C. diff. The team organized an interdisciplinary team that included nurses, physicians, and staff to screen patients and place orders for C. diff testing automatically.

1. Create BPA to reduce time to identify, treat, and isolate C. diff.
2. Physician BPA to notify the provider of the C. diff protocol for adult patients.
3. ED Nurse BPA to notify RNs once the criteria for testing have not been met or testing is not indicated.
4. Inpatient Nurse BPA to notify RNs once the criteria for testing have not been met or testing is not indicated.
5. Discrepancies in data documented in chart review.
6. Variance in workflows across the system.
7. High rates of hospital-onset CDI.
8. Rate of CDI that are not H/O CDI.
9. Rate of appropriate initial documentation.
10. Rate of patient isolation status.

The team used the Define, Measure, Analyze, Improve, and Control (DMAIC) methodology to organize their efforts. The team also developed a workflow diagram to help them visualize the process and track the data points associated with CDI.

In order to meet the NYSDOH performance goals for CDI, the organization developed protocols to help reduce rates of CDI.

- **Standardize Workflows Across the System**
  - Created ED Nurse BPA to notify the provider of the C. diff protocol for adult patients.
  - Developed Physician BPA to notify the provider of the C. diff protocol for adult patients.
  - Developed Inpatient Nurse BPA to notify RNs once the criteria for testing have not been met or testing is not indicated.
  - Discrepancies in data documented in chart review.
  - Variance in workflows across the system.
  - High rates of hospital-onset CDI.
  - Rate of CDI that are not H/O CDI.
  - Rate of appropriate initial documentation.
  - Rate of patient isolation status.

The team also used data to track the changes and determine whether further action would be necessary.

- **Collect Data on CDI Rates**
  - CDI Process Compliance Score Cards
  - C. diff Testing Rates
  - Hospital Onset CDI Rates
  - Improve communication among staff
  - Increase compliance and understanding of the C. diff Protocol for Adult Patients

**Looking Forward**

- **Continued Improvement**
  - Monthly meetings to review rates
  - CDI Process Compliance Score Cards
  - Lessons Learned

**References**


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**Evidence-Based Practice**

- Developing protocols to help reduce time to identify, treat, and isolate C. diff
- Physician BPA to notify the provider of the C. diff protocol for adult patients
- ED Nurse BPA to notify RNs once the criteria for testing have not been met or testing is not indicated
- Inpatient Nurse BPA to notify RNs once the criteria for testing have not been met or testing is not indicated
- Discrepancies in data documented in chart review
- Variance in workflows across the system
- High rates of hospital-onset CDI