



SGSV  
SSSH  
SSSO

Schweizerische Gesellschaft für Sterilisationsvorgang  
Société de Stérilisation Hospitalière  
Società Svizzera di Sterilizzazione Ospedaliera



**GIORNATA DI FORMAZIONE IN TICINO**

Un percorso attraverso  
la sterilizzazione

**Mille buone ragioni  
per ricondizionare *bene*  
lo strumentario chirurgico**

Mendrisio 09 ottobre 2013 - Matteo Moro, Milano



**Agenda**

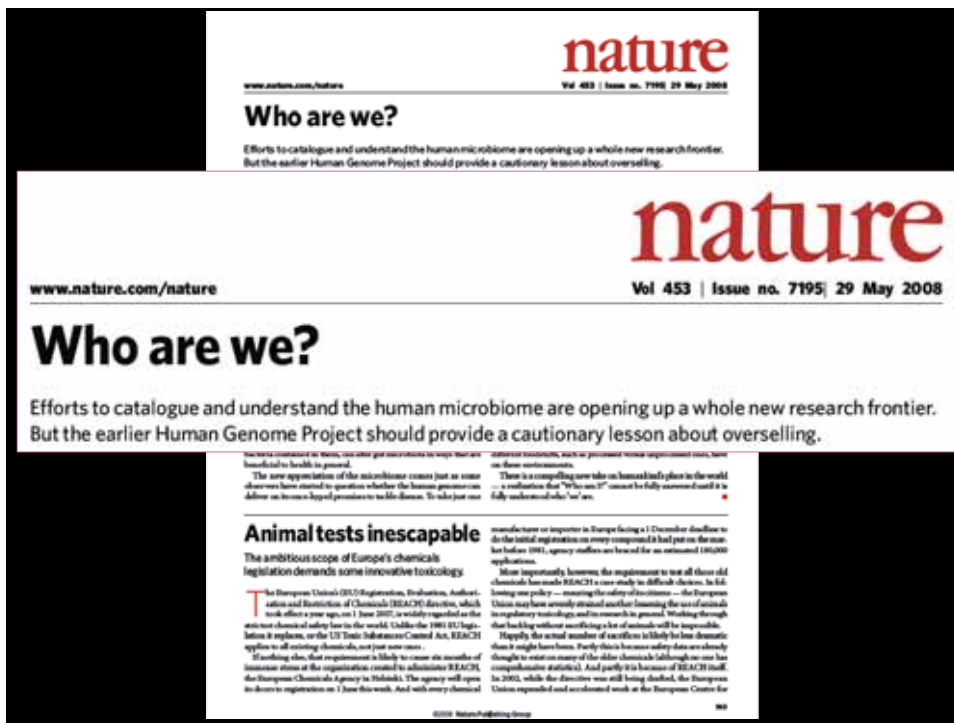
**Questione di  
... organismi  
macro e micro**

# Un confronto IMPARI

Cianobatteri: 3.500.000.000 anni

Homo sapiens: < 200.000 anni

Antibiotici: 80 anni



Agenda

Macro- e micro-organismi

# Questione di ... numeri

1. Burden of SSIs as complications in acute care facilities.
  - a. SSIs occur in 2%-5% of patients undergoing inpatient surgery in the United States.<sup>1</sup>

**ISC in 2 - 5 % interv. chirurgici**



**Con ISC 2 - 11 volte rischio di morte**

- b. Patients with an SSI have a 2-11 times higher risk of death compared with operative patients without an SSI.<sup>3,4</sup>

Original Investigation  
**Health Care–Associated Infections**  
 A Meta-analysis of Costs and Financial Impact

**Original Investigation**  
**Health Care–Associated Infections**  
**A Meta-analysis of Costs and Financial Impact**  
 on the US Health Care System

Eyal Zimlichman, MD, MSc; Daniel Henderson, MD, MPH; Orly Tamir, PhD, MSc, MHA; Calvin Franz, PhD; Peter Song, BSE; Cyrus K. Yamin, MD; Carol Keohane, BSN, RN; Charles R. Denham, MD; David W. Bates, MD, MSc

*JAMA Intern Med.* doi:10.1001/jamainternmed.2013.9763  
 Published online September 2, 2013.

Meta-analysis of Health Care–Associated Infections Original Investigation Research

**Table 2. Epidemiology of Health Care–Associated Infections Among US Adult Inpatients (Including ICUs) at Acute Care Hospitals, 2009\***

Health Care–Associated Infection Type	Incidence Rate	Population at Risk	Cumulative Incidence
Surgical site infections	1.98 <sup>b</sup>	8 020 658	158 639
MRSA	0.29 <sup>b</sup>	8 020 658	23 417
Central line–associated bloodstream infections	1.27 <sup>c</sup>	31 695 922	40 411
MRSA	0.21 <sup>c</sup>	31 695 922	6638
Catheter-associated urinary tract infections	1.87 <sup>d</sup>	41 115 000	77 079
Ventilator-associated pneumonia	1.33 <sup>d</sup>	23 392 785	31 130
Clostridium difficile infections	3.85 <sup>e</sup>	34 716 079	133 657
Total health care–associated infections	NA	NA	440 916

Abbreviations: ICU, intensive care unit; MRSA, methicillin-resistant *Staphylococcus aureus*; NA, not applicable.

\* Estimates based on data from National Healthcare Safety Network (2009) and National Inpatient Sample (2009). Incidence rate for *Clostridium difficile* infections based on systematic review of literature.

<sup>b</sup> Incidence rate in cases per 100 patient procedures; population at risk in total patient procedures.

<sup>c</sup> Incidence rate in cases per 1000 device-days; population at risk in total device-days.

<sup>d</sup> Incidence rate in cases per 1000 patient-days; population at risk in total patient-days.

<sup>e</sup> Incidence rate in cases per 1000 patient-days; population at risk in total patient-days.

**158,000 ISC su 8,000,000 interventi**

**Table 1. Estimates of Costs and LOS Attributed to the 5 Major Health Care-Associated Infections for the US Adult Inpatient Population at Acute Care Hospitals<sup>a</sup>**

Health Care-Associated Infection Type	Cost, 2012 \$US	LOS (as Total ICU d)
Surgical site infections	20 785 (18 902-22 667) <sup>b</sup>	11.2 (10.5-11.9) <sup>b</sup>
MRSA	42 300 (4005-82 670) <sup>b</sup>	23.0 (14.3-31.7) <sup>b</sup>
Central line-associated bloodstream infections	45 814 (30 919-65 245) <sup>b,c</sup>	10.4, 6.9 (6.9-15.2, 3.5-9.6) <sup>b,c</sup>
MRSA	58 614 (16 760-174 755) <sup>c</sup>	15.7 (7.9-36.5) <sup>c</sup>
Catheter-associated urinary tract infections	896 (603-1189) <sup>b</sup>	NR
Ventilator-associated pneumonia	40 144 (36 286-44 220) <sup>b,c</sup>	13.1, 8.4 (11.9-14.3, 7.8-9.0) <sup>b,c</sup>
<i>Clostridium difficile</i> infections	11 285 (9118-13 574) <sup>b</sup>	3.3 (2.7-3.8) <sup>b</sup>

**20.000 - 42.000 \$ per ISC**

<sup>a</sup> Abbreviations: ICU, intensive care unit; LOS, length of stay; MRSA, methicillin-resistant *S. aureus*; NR, not reported; LOS reported as mean (range). <sup>b</sup> LOS estimates obtained from literature and 100 000-trial Monte Carlo simulations using triangular distribution. <sup>c</sup> Estimates obtained from literature and 100 000-trial Monte Carlo simulations, using general distribution.

**Table 3. Total Attributable Financial Impacts of Health Care-Associated Infections in US Adult Inpatients at Acute Care Hospitals, 2009<sup>a</sup>**

Health Care-Associated Infection Type	Costs		
	Total	Lower Bound	Upper Bound
Surgical site infections	3 297 285 451	2 998 570 584	3 595 841 680
MRSA	990 539 052	93 785 080	1 935 883 296
Central line-associated bloodstream infections	1 851 384 347	1 249 464 195	2 636 608 279
MRSA	389 081 519	111 253 391	1 160 029 019
Catheter-associated urinary tract infections	27 884 193	18 765 813	37 002 574
Ventilator-associated pneumonia	3 094 270 016	2 796 898 212	3 408 445 101
<i>Clostridium difficile</i> infections	1 508 347 070	1 218 707 008	1 814 293 587
Total	9 779 171 077	8 282 405 811	11 492 191 220

**3.297.000.000 \$ costo ISC in USA (adulti) / anno**



## Una minaccia seria

- Sally Davies, CMO Dept Health UK, described CREs as a risk as serious as terrorism.
- "We have a very serious problem, and we need to sound an alarm" said Tom Frieden, Director of the US CDC.
- They warn of a coming health "nightmare" and a "catastrophic threat".



**2.5 BURDEN OF NOSOCOMIAL INFECTIONS**

the number of hospital admissions in the EU 27 (498 million inhabitants) is approximately 81 million per year (on average 16 247 admissions per 100 000 inhabitants per year).

The yearly number of patients with at least one nosocomial infection in the EU 27 can thus be estimated at 4 131 000 patients.

Since patients will often get more than one infection during the same hospitalisation (average from the national prevalence surveys review is 1.1 infections per infected patient) the yearly number of nosocomial infections can be estimated at 4 544 100.

500 M ab. EU

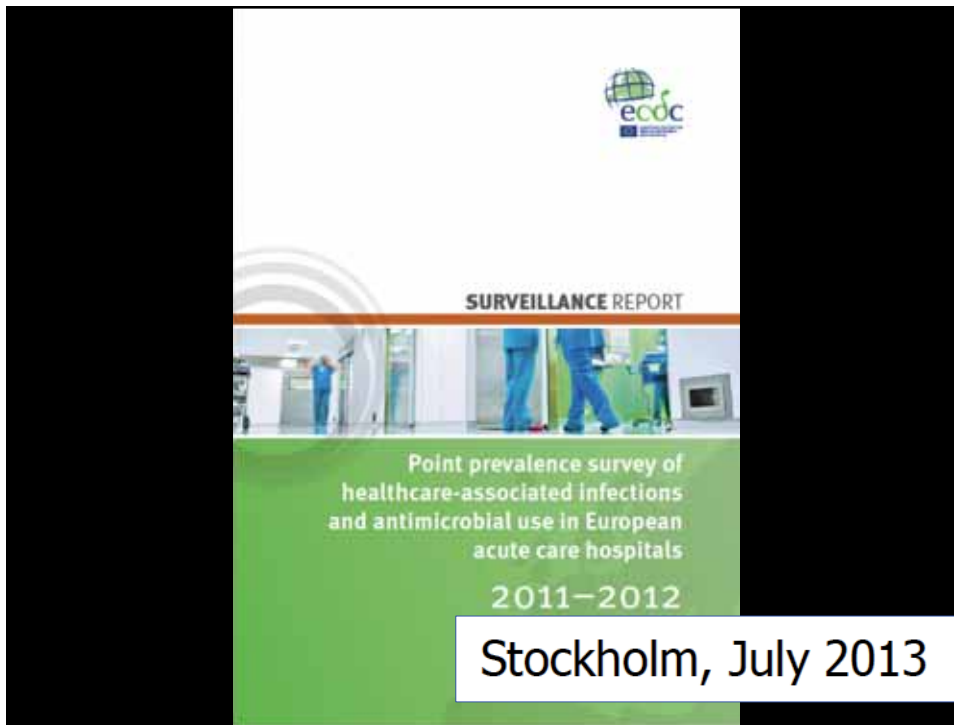
81 M ricoveri

>4 M di pz con ICA

The prevalence studies were urinary tract infections (27%), lower respiratory tract infections including pneumonia (24%), surgical site infections (17%) and bloodstream infections (10.5%). The remaining infection sites represent on average 19.3% of the prevalence survey overview

17 % di 4.544.100  
 ≈ 770.000 ISC / anno in EU

ISC  
 SSI



**Table 11. Prevalence of HAI by HAI type and relative frequency of HAI types, ECDC PPS 2011–2012**

	N of patients with HAI	HAI%	N of HAIs	Rel%
<b>All HAI types</b>	<b>13829</b>	<b>6.0</b>	<b>15000</b>	<b>100</b>
Pneumonia	2902	1.3	2907	19.4
Other lower respiratory tract infections	607	0.3	609	4.1
<b>Surgical site infections</b>	<b>2933</b>	<b>1.3</b>	<b>2941</b>	<b>19.6</b>
Urinary tract infections	2848	1.2	2848	19.0
Bloodstream infections	1576	0.7	1585	10.6
Catheter-related infections without bloodstream infection	233	0.1	233	1.6
Cardiovascular system	141	0.1	141	1.4
Gastro-intestinal system	141	0.1	141	7.6
Skin and soft tissue	119	0.1	119	4.0
Bone and joint infections	115	0.1	115	1.6
Central nervous system	107	0.1	107	0.6
Eye, ear, nose or mouth infection	454	0.2	454	3.0
Reproductive tract infections	87	0.0	87	0.6
Systemic infections <sup>(a)</sup>	933	0.4	934	6.2
Other/unknown	123	0.1	123	0.8

(a) Including Clostridium difficile infections 3.6%.  
 (b) Including clinical sepsis 5.4%.

17 % stime ecdc 2008  
 ≈ 19,6% PPS 2011



The screenshot shows the Swissnoso website interface. At the top, the logo 'SWISSNOSO' is displayed in green. Below it, a navigation bar includes 'HOME', 'INFORMAZIONI', 'RETE', and 'ABBONAMENTO'. A sidebar on the left contains 'BULLETIN' and 'SURGICAL SITE INFECTION'. The main content area features a large image of a surgeon in a blue cap and mask, with the text 'Swissnoso » Home » Infezioni ospedaliere in Svizzera'. Below the image, a 'Novita\*' section is dated '23 August 2013' and titled 'Infezioni ospedaliere in Svizzera'. The text below the title reads: 'Infezioni ospedaliere in Svizzera: si stimano circa 2'000 decessi all'anno'. To the right, there is a white box with the 'anq' logo and 'SWISSNOSO' text, containing the title 'Rapporto riassuntivo 2010/2011' and 'Programma nazionale di rilevamento delle infezioni del sito chirurgico'. Below this, it states 'Scritto da Swissnoso su mandato dell'ANQ' and provides details about the survey period from July 2010 to September 2011, along with the names of the project coordinators: 'Prof. Dr. med. Christian Paul Hans Christian Stamm' and 'Prof. Dr. med. Nicole Trüdel'. The date 'Giugno 2012 versione 1.0' is also visible.

### Infezioni ospedaliere in Svizzera: si stimano circa 2'000 decessi all'anno

Dal momento che in Svizzera non disponiamo di dati statistici completi e differenziati sulla frequenza delle infezioni acquisite in ospedale, questi devono essere estrapolati partendo dai dati esistenti che sono in parte lacunosi.

Il gruppo di esperti Swissnoso stima che in Svizzera ogni anno approssimativamente 70'000 persone acquisiscano un'infezione in ospedale e che questa risulti in un decesso in circa 2'000 casi. Queste cifre si basano su estrapolazioni fatte a partire dai dati di cui disponiamo a livello nazionale tenendo conto dei valori di referenza internazionali. Trattandosi di stime piuttosto prudenti, le cifre reali potrebbero essere più elevate.

Swissnoso ritiene che almeno il 30% delle infezioni ospedaliere potrebbero essere evitate tramite una prevenzione efficace. Partendo dal presupposto che attualmente nelle strutture ospedaliere svizzere non tutti i pazienti beneficiano in modo sistematico di tutte le misure di prevenzione scientificamente provate, Swissnoso è ora impegnato nello sviluppo e nell'implementazione del programma *Swiss Clean Care* con misure mirate ad impedire l'acquisizione delle infezioni ospedaliere.

Berna, il 23 agosto 2013

**2.000 morti / anno  
per tutte le infez. osped.**

**Tabella 1: numero di ospedali partecipanti per ogni tipo di intervento e numero di casi rilevati tra l'1.6.2009 e il 30.9.2011 per la chirurgia viscerale e il taglio cesareo, e tra l'1.6.2009 e il 30.9.2010 per l'ortopedia e la chirurgia cardiaca.**

Tipo di intervento	Numero di ospedali partecipanti	Totale casi
Appendicectomia	31	2393
Colecistectomia	48	4889
Interventi di ernia	34	6907
Chirurgia del colon	76	8148
Taglio cesareo	40	13'802
Intervento al retto	11	268
Bypass gastrico	4	168
Chirurgia cardiaca*	9	3246
Protesi totale dell'anca*	57	8916
Protesi totale del ginocchio*	33	3647
	<b>84</b>	<b>52'384</b>

\* Dopo questi interventi con protesi è necessario un follow-up di un anno.

>50.000 interventi sorvegliati

Tipo di intervento	infezioni	interventi	%	Superf	Prof	O-S
<b>Appendicectomia</b>	<b>67</b>	<b>1744</b>	<b>3,8</b>	1,3	0,5	2,1
Con laparoscopia	48	1345	3,6			
Con laparotomia	19	399	4,8			
<b>Colecistectomia</b>	<b>103</b>	<b>3419</b>	<b>3,0</b>	1,7	0,3	1,1
Con laparoscopia	57	3047	1,9			
Con laparotomia	46	372	12,4			
<b>Interventi di ernia</b>	<b>54</b>	<b>4398</b>	<b>1,2</b>	1	0,3	0,02
<b>Chirurgia del colon</b>	<b>660</b>	<b>5142</b>	<b>12,8</b>	4,6	1,9	6,3
Con laparoscopia	116	1733	6,7			
Con laparotomia	544	3409	16,0			
<b>Bypass gastrico</b>	<b>28</b>	<b>168</b>	<b>16,7</b>	12,5	1,8	2,4
<b>Taglio cesareo</b>	<b>142</b>	<b>8033</b>	<b>1,8</b>	1,2	0,1	0,5
<b>Protesi dell'anca</b>	<b>146</b>	<b>8916</b>	<b>1,6</b>	0,5	0,5	0,6
<b>Protesi del ginocchio</b>	<b>72</b>	<b>3647</b>	<b>2,0</b>	0,7	0,7	0,6
<b>Chirurgia cardiaca</b>	<b>175</b>	<b>3246</b>	<b>5,4</b>	2,2	1,4	1,8

>1.500 ISC (1,2-16,7%)

A vertical graphic on the left side of the slide, resembling a roll of paper or a scroll, with the word "Agenda" written vertically in a dark, serif font. The graphic has a textured, brownish background and is framed by a red border.

- Macro- e micro-organismi
- Le ISC

**Questione di persone !**

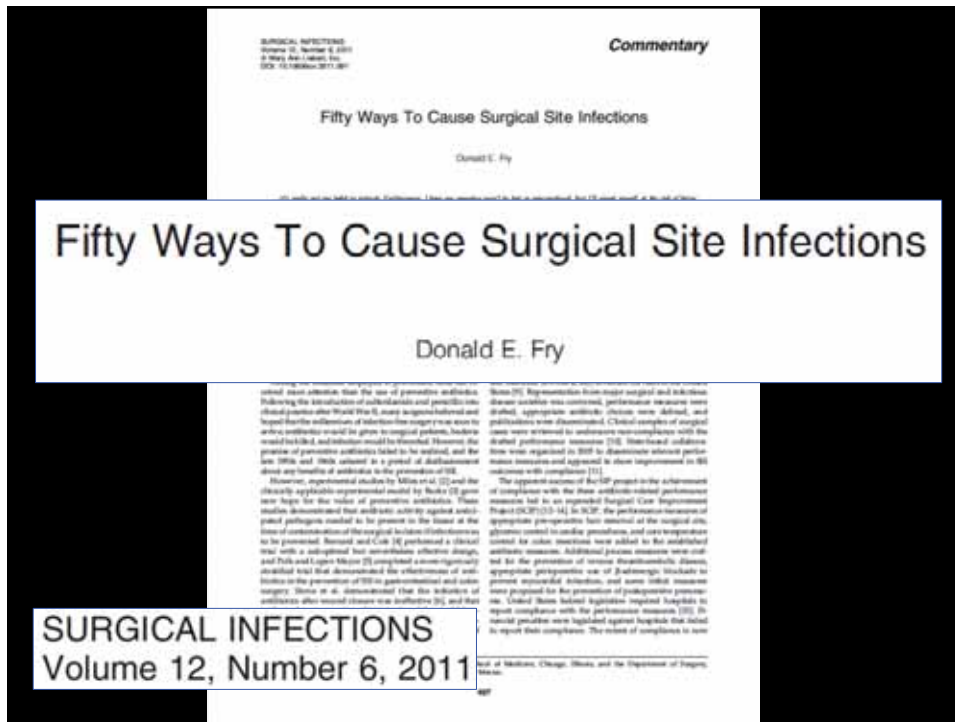
### Etsuro Sotoo

*Osservavo questi medici volontari intervenuti dopo lo tsunami: **per prima cosa salutano gli ammalati.***

*Per quanto la situazione sia urgente e tragica, quell'**inchino** significa esattamente questo: **pensare agli altri** (...)*

*Come io, scultore, devo chiedere permesso alla pietra, prima di iniziare a scolpirla, così anche loro **devono inchinarsi** davanti a quegli uomini prima di curarli.*

"Tracce" Aprile 2011



**TABLE 1. FIFTY CO-MORBIDITIES, RISK FACTORS, AND TREATMENT PARAMETERS ASSOCIATED WITH CAUSATION OR PREVENTION OF POST-OPERATIVE SURGICAL SITE INFECTIONS (SSIs)**

Nutritional status/hypalbuminemia	Chronic lung disease	Intraoperative "spill"	Length of operation
Blood sugar	Hypothermia	Glove/barrier failure	Operating room traffic
Diabetes mellitus	Drug abuse	Contaminated surgical instruments	Hand hygiene
Obesity	Chronic liver disease	Contaminated field/irrigation fluid	Preoperative antimicrobial scrub/shower
Age	Malignant disease/pre-operative	Foreign bodies/implants/braided sutures	

**L'ISC è un evento multifattoriale!**

Strumentario - DMR sterili sono solo uno dei fattori in gioco

ma un fattore importante, e sotto la nostra responsabilità.

**Agenda**

- Macro- e micro-organismi
- Le ISC
- Questione di persone !

# Responsabilità

**NEJM 2009**

**Balancing "No Blame" with Accountability in Patient Safety**  
 Robert M. Wachter, M.D., and Peter J. Pronovost, M.D., Ph.D.

**THE "NO BLAME" VERSUS ACCOUNTABILITY**

This year marks the 50th anniversary of the Institute of Medicine's report *To Err Is Human*, the document that launched the modern patient-safety movement. Although the movement has spawned myriad initiatives, its main theme, drive. Even studies of other high-risk industries that have improved safety records, both done to this. Most areas are concerned by good, handwriting people trying to do the right thing. Therefore, the traditional focus on identifying who is at fault is a distraction. It is to serve patients to identify error-prone situations and settings and to implement systems that prevent caregivers from committing errors, catch errors before they cause harm, or mitigate harm from errors that do reach patients.<sup>1,2</sup>

Most health care providers embraced the "no-blame" model as a refreshing change from an error landscape previously dominated by a punitive system that was perceived as punitive and arbitrary. And this shift has understandably fostered, for example, rather than trying to punish doctors' handwriting and medication management errors catch medication errors before they reach patients. Many health care organizations including ours have recognized that a fundamental dilemma in creating a blame-free culture centers on how safety risks. But despite this recognition, finding the appropriate balance has been elusive, and few organizations have implemented meaningful systems of accountability, particularly the physician. In this article, we describe some of the barriers to physician accountability, examine patient-safety practices that are useful for an accountability approach, and suggest practices for the future to address such practices. We focus on situations in which the actions of individual physicians pose a clear risk to patients, rather than on the broader issues of clinical competence or disruptive behaviors, neither of which are addressed if the latter issues are referred to other sources.<sup>3,4,5</sup>

It should also be noted that the Institute of Medicine report was due to flawed systems or provider behavior, these actions made sense.

Despite these efforts, most hospitals continue to have had negative rates that range from 30 to 70%, and few have sustained rates over 50%. We have had the experience of asking thousands how

physicians' and the Joint Commission has made addressing the problem of disruptive behaviors a priority.<sup>6</sup> Guidelines identified the need to create accountability for the failure to perform based by given. Rather than a "no-blame" culture, there emerged a "just culture," which differentiates blame-worthy from blameless acts.<sup>7,8</sup>

changes. To the degree that the failure to show hands was due to flawed systems or provider behavior, these actions made sense.

Despite these efforts, most hospitals continue to have had negative rates that range from 30 to 70%, and few have sustained rates over 50%. We have had the experience of asking thousands how

Downloaded from www.nejm.org at ULEA BIBL (CCAB) on September 23, 2015.  
 Copyright © 2009 Massachusetts Medical Society. All rights reserved.

## In presenza di certi pre-requisiti ...

**Table 1. Prerequisites for Making the Choice to Punish Providers for Not Adhering to a Patient-Safety Practice, Using the Example of Hand Hygiene.**

Prerequisite	Example of Hand Hygiene
The patient-safety problem that is being addressed is important.	Rates of health care-associated infections are unacceptably high, resulting in serious morbidity and mortality. <sup>18</sup>
The literature or expert consensus strongly supports adherence to the practice as an effective strategy to decrease the probability of harm.	Many studies and long-standing expert consensus support the value of hand hygiene, <sup>19</sup> and health care-associated infections are now reported publicly and are subject to "no pay" initiatives. <sup>20a</sup>
Clinicians have been educated about the importance of the practice and the evidence supporting it.	Lectures, reminder systems, academic detailing, dissemination of literature, and other steps to educate caregivers have been completed.
The system has been modified, if necessary, to make it as easy as possible to adhere to the practice without disrupting other crucial work or creating unanticipated negative consequences; concerns by providers regarding barriers to compliance have been addressed. <sup>†</sup>	Hand-gel dispensers have been placed in convenient locations throughout the building; dispensers are never empty and work well (e.g., they do not squirt gel onto providers' clothes).
Physicians, other providers, and leaders have reached a consensus on the value of the practice and the process by which it will be measured; physicians understand the behaviors for which they will be held accountable.	Meetings have been held with relevant provider groups, including medical staff, to review the evidence behind hand hygiene, the rates of hospital-acquired infections, and the steps that have been taken to optimize the system.
A fair and transparent auditing system has been de-	Providers know that observers will periodically audit

## ... si possono punire gli inadempienti

**Table 2. Examples of Patient-Safety Practices, with Suggested Penalties for Failure to Adhere to Practice.**

Patient Safety Practice	Suggested Initial Penalty for Failure to Adhere to Practice <sup>a</sup>
Practicing hand hygiene	Education and loss of patient-care privileges for 1 wk
Following an institution's guidelines regarding provider-to-provider sign-out at the end of a shift	Education and loss of patient-care privileges for 1 wk
Performing a "time-out" before surgery	Education and loss of operating room privileges for 2 wk
Marking the surgical site to prevent wrong-site surgery	Education and loss of operating room privileges for 2 wk
Using the checklist when inserting central venous catheters	Counseling and review of evidence, <sup>a</sup> loss of catheter-insertion privileges for 2 wk


<sup>a</sup> These penalties would be applied only in cases in which a clinician did not respond to initial warnings and counseling. Continued failure to adhere to the practice after the initial penalty would lead to permanent loss of clinical privileges (for physicians) or firing, in keeping with the relevant medical staff or human resource policy. Stress management and other behavioral interventions should be considered as possible adjunct approaches when a caregiver chronically fails to adhere to agreed-upon safety standards.<sup>32</sup>



# Responsabilità ...

**individuale ?** Do we need an ethical framework for hospital infection control?  
M. Millar\* Journal of Hospital Infection (2009) 73, 232–238

**di gruppo ?** **Microsystems in Health Care:**  
Part 1. Learning from High-Performing Front-Line Clinical Units

**dell'organizzazione ?**   
Healthcare associated infection: what else can the NHS do?

# Agenda

- Macro- e microrganismi
- Le ISC
- Questione di persone !
- Responsabilità

## Zero tolerance



Surgical Site Infection (SSI) Toolkit  
Activity C: IIC Prevention Collaboratives  
3110 Barnes Tower, 8th  
Division of Healthcare Quality Promotion  
Centers for Disease Control and Prevention

### Preventability of Healthcare-Associated Infections

What proportion of healthcare infections are caused by errors... i.e. are preventable?

Medical Errors and Near-misses

Healthcare-associated Infections

CDC's SENIC Study- 1970's

### Preventability of Healthcare-Associated Infections

What proportion of healthcare infections are caused by errors... i.e. are preventable?

Medical Errors and Near-misses

Healthcare-associated Infections

"targeting zero"

Goal: Best quality of patient care and elimination of preventable healthcare-associated infections

VIEWPOINTS

**“Never Events”: Not Every Hospital-Acquired Infection Is Preventable**

*Jack Knaus,<sup>1,2</sup> Fred Schwanen III,<sup>3,4</sup> and Joseph M. Mouton<sup>5</sup>*

<sup>1</sup>Department of Hospital Medicine, University of Michigan Medical Center, Ann Arbor, Michigan; <sup>2</sup>Department of Hospital Practice, School of Hospital and Professional Studies, and <sup>3</sup>Department of Health and Healthcare Services, School of Public Health, San Diego State University, San Diego, California; <sup>4</sup>Department of Medicine, Department of Pediatrics, and <sup>5</sup>Department of Medicine and Infectious Diseases, School of Medicine and Biomedical Sciences, State University of New York, and <sup>6</sup>Department of Pharmacy, Yale University School of Medicine, New Haven, Connecticut

Medicine stopped monitoring United States hospitals for several complications or conditions developed during hospital admissions effective 1 October 2008. The Centers for Medicare and Medicaid Services selected high-cost or high-frequency events from the National Quality Forum’s list of “never events” for inclusion in this reimbursement change. Several of these

“Never Events”: Not Every Hospital-Acquired Infection Is Preventable

**“Nessun caso”:  
NON tutte le ICA sono prevenibili**

**CID 2009:49 (1 September)**

VIEWPOINTS

**The “Zero Risk” Concept for Hospital-Acquired Infections: A Risky Business!**

*Jose Carlet,<sup>1</sup> Josep Tabak,<sup>2</sup> Berni Amador,<sup>3</sup> and Laurent Duperon<sup>4</sup>*

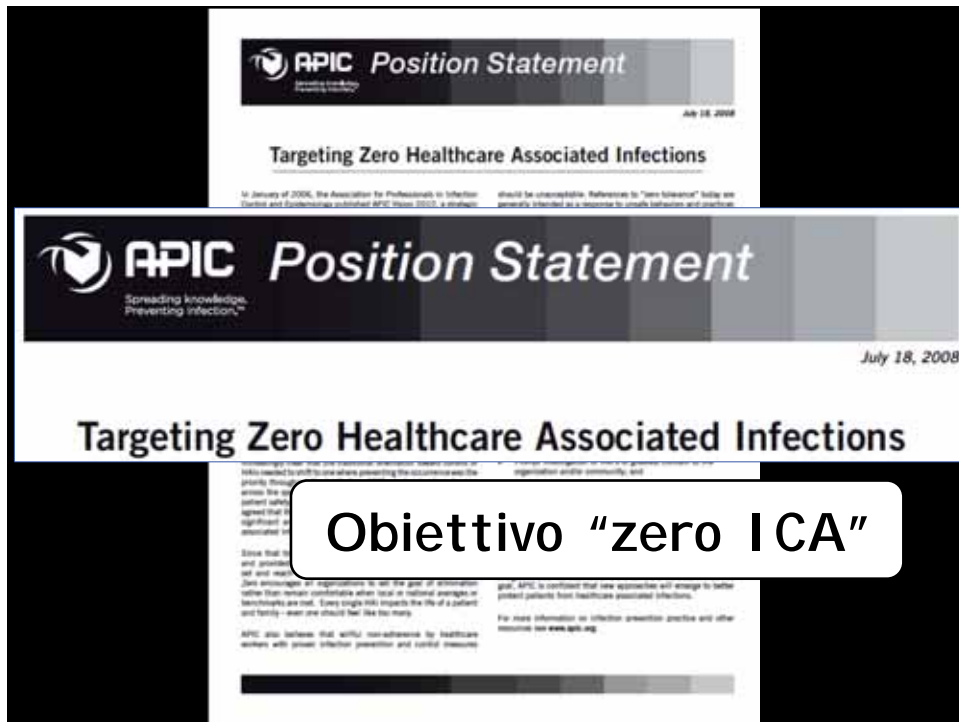
<sup>1</sup>Unidad de Neumología, Hospital General de Valencia, Valencia, Spain; <sup>2</sup>Unidad de Neumología, Hospital General de Valencia, Valencia, Spain; <sup>3</sup>Unidad de Neumología, Hospital General de Valencia, Valencia, Spain; <sup>4</sup>Unidad de Neumología, Hospital General de Valencia, Valencia, Spain

Nonventilator infections represent a serious public health problem. Some recent studies, most of which used strong educational programs, showed a dramatic decrease in the rates of nonventilator infections, particularly culture-related infections in the intensive care unit. Thus, the concept of “zero risk” is flourishing in the recent literature, and some insurance networks have decided to limit reimbursement for treatment of some of the health care-associated infections, on the grounds that most of them are preventable. This viewpoint article emphasizes the risk of such a practice and summarizes the reasons why such a philosophy could be counterproductive. In particular, this philosophy does not fit with the concept of self-declaration of serious adverse events and could create obstacles to implement these events.

The “Zero Risk” Concept for Hospital-Acquired Infections: A Risky Business!

**Il concetto “rischio zero” per le ICA:  
un affare rischioso !**

**CID 2009:49 (1 September)**



## TARGETING ZERO

A culture of targeting zero healthcare associated infections **and zero tolerance for unsafe practices** is characterized by the following:

- ✓ Setting the **theoretical goal of elimination** of HAIs
- ✓ An expectation that infection prevention and control (IPC) measures will be **applied consistently by all healthcare workers, 100% of the time**