SYNERGY: COMBINING EFFORTS FOR HAI PREVENTION

April 2012

News from the Virginia Department of Health's Healthcare-Associated Infections (HAI) Program

Volume 3, Issue 4

Edited by: Andrea Alvarez

Notes from VDH

Happy spring, everyone!

I recently had a chance to give some long-term care infection prevention updates at an educational session for directors of nursing and in-service educators in long-term care facilities provided by the Virginia Association of Nonprofit Homes for the Aging (VANHA) in Roanoke. It was nice to get out of the office and enjoy the mountain air! We hope to see many of you around the state at meetings and events over the spring and summer.

- Andrea, HAI Program Coordinator

For those of you interested in advocating for sustained levels of funding for the National Healthcare Safety Network, consider sending an e-mail or writing a letter to Congress: **http://capwiz.com/apic/home/**

Reminder—register for the *free* webinar:

SIR 201: Calculating the SIR in NHSN and Generating Reports

When: Thursday, May 3rd, 1-2:30PM

Topics addressed:

- Derivation of CLABSI and SSI SIR
- SIR data quality tips to ensure compliance with requirements
- How to generate & modify NHSN SIR reports

Audience: infection preventionists, those interested in SIR nuts and bolts

Registration site:
http://www.anymeeting.com/PIID=EC58DA82884C

2010 National and State-Specific NHSN SIR Report

On April 19, the Centers for Disease Control and Prevention (CDC) published the National and State Healthcare-Associated Infections Standardized Infection Ratio (SIR) Report (Jan-Dec 2010) using data from the National Healthcare Safety Network. The report contains national statistics on central line-associated bloodstream infections (CLABSIs), surgical site infections following 10 surgical procedures, and catheter-associated urinary tract infections as well as state-specific data on CLABSIs.

Virginia observed 372 CLABSIs in 2010 and had a SIR of 0.67, meaning that Virginia's hospitals had 33% fewer infections than predicted when compared to the baseline U.S. experience. The number of CLABSIs in the SIR report differs from the 2010 quarterly reports posted by VDH because CDC included data from all patient care locations in Virginia hospitals whereas VDH's analysis was limited to adult intensive care units in acute care and critical access hospitals.

Between 2009 and 2010, Virginia's CLABSI SIR decreased from 0.82 to 0.67; this change was statistically significant and may be a result of several factors including hospital-based quality improvement initiatives and public reporting.

To access the complete SIR report, go to: **http://www.cdc.gov/hai/national-sir-jan-dec-2010/index.html**

In this issue:

Upcoming Events:

May 3—1 PM: SIR 201: Calculating the SIR in NHSN and Generating Reports (VDH webinar)

June 13-14: VHQC QualitySync Conference, Richmond

June 27: VDH Field Epi Seminar, Richmond

Contact:

Andrea Alvarez, HAI Program Coordinator with questions / comments: 804-864-8097

FDA Safety Communication: Other–Sonic Generic Ultrasound Transmission Gel and Risk of Bacterial Infection

On April 18th the Food and Drug Administration (FDA) issued a safety communication about the risk of *Pseudomonas aeruginosa* colonization or infection following the use of **Other-Sonic Generic Ultrasound Transmission Gel**, which has been found to be contaminated with *P. aeruginosa* and *Klebsiella oxytoca*. Note that this product is not labeled as sterile and is NOT sterile.

Sixteen patients in one hospital who were examined with transesophageal ultrasound probes using Other-Sonic Generic Ultrasound Transmission Gel developed colonization or infection with *P. aeruginosa* and the FDA is concerned about contamination of this product with **lot numbers 060111 through 120111**. These lots contain 250 milliliter (mL) bottles and 5 liter (L) dispensing containers of gel. The lot number is printed on each bottle. The lots were manufactured June through December 2011 by Pharmaceutical Innovations.

Recommendations for Health Care Professionals and Facilities Regarding Other-Sonic Generic Ultrasound Transmission Gel

- **Do NOT use** Other-Sonic Generic Ultrasound Transmission Gel from lot numbers 060111 through 120111.
- Identify patients who have been exposed to these lots of Other-Sonic Generic Ultrasound Transmission Gel. Review the procedures they underwent and the outcomes of those procedures to determine if further evaluation is needed.
- To report adverse events associated with use of the contaminated gel, contact Pharmaceutical Innovations Inc. at 973-242-2900 (897 Frelinghuysen Avenue, Newark, NJ 07114). Refer to your facility's infection control or other risk control procedures for appropriate disposal of Other-Sonic Generic Ultrasound Transmission Gel.

To access the full FDA Safety Communication, go to: **http://www.fda.gov/MedicalDevices/Safety/AlertsandNotices/ucm299409.htm**

Updated National Action Plan to Prevent HAIs

On April 19th, the U.S. Department of Health and Human Services (HHS) released their *National Action Plan to Prevent Healthcare-Associated Infections: A Roadmap to Elimination* with a revised chapter for Phase 1 (acute care hospitals) and a draft chapter for Phase 2 (ambulatory surgery centers, dialysis facilities, and increasing influenza vaccination among healthcare personnel).

The HHS HAI Action Plan can be accessed at: **www.hhs.gov/ash/initiatives/hai/actionplan/index.html**.

To make comments on the revised plan, contact **OHQ@hhs.gov** before June 25th. A draft chapter for Phase 3 (long-term care facilities) is slated for release next month and will be followed by a public comment period as well.

CDC / American College of Surgeons Partnership

The Centers for Disease Control and Prevention (CDC) and the American College of Surgeons (ACS) have joined in a strategic partnership to improve surgical patient safety on a national level. The alliance will strengthen quality health care by combining the expertise and resources of these two organizations to improve tracking, reporting, and prevention of surgical site infections (SSIs) and other adverse surgical outcomes. This partnership will bring clinicians, surveillance experts, and prevention leaders together to improve data collection and maximize patient safety.

A critical objective of this collaboration is to improve data exchange between ACS and CDC systems and to maximize the use of electronic health records for collecting and submitting standard SSI measures and other data to aggregating systems (the National Healthcare Safety Network and the ACS National Surgical Quality Improvement Program). Joint analyses and reports using shared data collected from the unique systems will support efforts to further develop quality of care measures. An initial three-year period has been defined for this collaboration.

New HAI Resources and Documents: The Joint Commission, AHRQ, and VDH

The Joint Commission HAI Portal

The Joint Commission recently released an HAI Portal online to provide an integrated "kiosk" of HAI resources. Some resources are free while others are available for purchase. The HAI Portal is organized into three sections: *HAI Topics*, *HAI Information by Setting*, and *Infection Prevention and Control*. After clicking on the section of interest, information is separated into "Joint Commission Content", "Joint Commission Resources/ Joint Commission International Content", and "Center for Transforming Healthcare Content". The HAI Portal can be viewed at **http://www.jointcommission.org/hai.aspx.**

AHRQ Quality Indicators Toolkit for Hospitals

The free online toolkit is designed to help hospitals understand the Quality Indicators from the Agency for Healthcare Research and Quality (AHRQ) and help use improvement methods to successfully improve quality and patient safety. It focuses on the 17 Patient Safety Indicators and the 28 Inpatient Quality Indicators. More information can be found at **www.ahrq.gov/qual/qitoolkit/**.

VDH HAI Website Updates

New documents available since last month include two final reports of projects conducted in 2010 and 2011 using American Recovery and Reinvestment Act (ARRA) funds:

- Central Line-Associated Bloodstream Infection Data Audit Project Final Report

  http://www.vdh.virginia.gov/epidemiology/surveillance/hai/CLABSI_Reporting.htm#webinar

- Surgical Site Infection (SSI) Surveillance Pilot, Data Presentation Collaborative, and SSI Mini-Grant Report

  http://www.vdh.virginia.gov/epidemiology/surveillance/hai/ssi.htm#VDHHAI

Many thanks to those facilities that participated in any (or all!) of the projects summarized in the reports.

The number of hits to the website is on the rise (~3,200 in February and over 4,000 in March)!

Continue to check the site for new documents! **www.vdh.virginia.gov/epidemiology/surveillance/hai**

New HAI Tools from VHQC

As an experienced healthcare provider, you know the risks associated with central line and urinary catheter use. You also understand that protocols for monitoring and reporting adherence to central line and urinary catheter insertion practices will reduce these risks.

In response to your feedback, VHQC (the state quality improvement organization) has developed several new resources that you can use to make a positive change in your facility's central line and catheter practices.

Participants in VHQC's healthcare-associated infections (HAI) learning and action network also receive training on tools like these, and enjoy opportunities to learn from other providers who are tackling the same HAI challenges. Please contact Jennifer Reece (**jreece@vaqio.sdps.org**) to learn how you can participate.

Central Line/Foley Catheter Daily Assessment Form

Central Line Insertion Practices Adherence Monitoring

Urinary Catheterization Sample Policy

"Promptly Remove Urinary Catheters: A Focus on Patient Safety" brochure

Urinary Catheter Decision Making Algorithm

Urinary Catheter Pocket Card

You can access these resources through the VHQC Resource Center, under Healthcare-Associated Infections. Please share the materials with colleagues or use them in your own facility by including your logo and contact information.

Learn how you can benefit from getting involved!

IP and Lab Staff Communication: Preventing Transmission

Timely communication between infection preventionists and laboratory staff regarding infection, colonization, and/or susceptibility patterns helps identify transmission risk in order to implement the appropriate infection prevention practices. However, long turn-around times for laboratory tests as well as other challenges may delay receiving and acting upon these results, potentially increasing the risk of infection transmission within the facility.

To begin addressing these issues, the Association for Professionals in Infection Control and Epidemiology (APIC) and the American Society for Microbiology (ASM) worked together to implement a survey in 2011 that identified gaps and potential solutions. The majority of respondents worked in the hospital setting (81%), 78% were APIC members, and 22% were ASM members.

One example of a need for more rapid communication involved methicillin-resistant *Staphylococcus aureus* (MRSA). Over half (51%) of IPs surveyed indicated that they need results for MRSA screening tests within 12 hours to initiate the necessary precautions, although it takes 24-48 hours for results from MRSA cultures to be finalized. In addition, respondents demonstrated an interest in building partnerships between the IPs and the lab, and receiving more education about best practices. However, only 63% reported their facility had effective infrastructure in place for training and educating staff about HAIs.

Greater collaboration, communication, and education between labs and IPs has the potential to enable hospitals to manage HAIs more effectively. Hopefully the communication between IPs and the lab will increase, especially with the support from administration and IT. For more information, go to: **www.apic.org/labproject**

NHSN Q&A

Q. For surveillance purposes, is it important to distinguish irrigated urinary catheters from non-irrigated urinary catheters?

A. Due to an amendment in the CAUTI protocol that is effective as of April 1, 2012, it is no longer important to distinguish if the urinary catheters are irrigated. ALL indwelling urinary catheter days should be included in the CAUTI data and ALL patients with indwelling urinary catheters are eligible for CAUTIs, regardless of whether the catheter has been irrigated in ANY way.

Q. What if my laboratory does not report white blood cell counts lower than 5 for performed urinalyses?

A. Because many laboratories do not report white blood cells counts lower than 5 for urinalyses performed, starting on April 1st, 2012, all references of pyuria included in the UTI definitions are changed to "… or >5 WBC/high powerfield of spun urine".

Q. How should I handle reporting fever in patients with more than one potential HAI?

A. Fever is a non-specific sign and may be due to more than one infection if both are occurring at the same time. In the situation where it is impossible to determine whether the fever is due to one of the infections or both, the fever *must* be attributed to more than one cause at the same time. For more information and an example, refer to the March 2012 edition of NHSN e-News (**http://www.cdc.gov/nhsn/PDFs/Newsletters/NHSN-NL-March-2012.pdf**).

Q. What is the difference, if any, between a CLABSI and a CRBSI?

A. There are differences between a CLABSI and a CRBSI. A CLABSI is a central line-associated bloodstream infection and is based on an National Healthcare Safety Network (NHSN) standardized surveillance definition and not used for clinical management. A CRBSI is an intravascular catheter-related bloodstream infection and is used for clinical diagnosis and management as published by the Infectious Diseases Society of America (IDSA). In addition, the definition components between CLABSI and CRBSI differ. For example, the NHSN CLABSI definition does not utilize catheter-tip cultures nor recommend collecting blood cultures through vascular catheters, while both are components in the CRBSI definition. For more information see IDSA or NHSN.