SYNERGY: COMBINING EFFORTS FOR HAI PREVENTION

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

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Edited by:
Andrea Alvarez

Notes from VDH

Happy holiday season, everyone! We hope that you will be able to relax and enjoy time with family and friends.

Our last newsletter of the year is full of information about surveillance updates, meeting recaps, and tips on how to spread holiday cheer and not disease!

The HAI Epidemiologist position is currently in recruit and we hope to have it filled in the next month or so. This person will have primary responsibility for providing National Healthcare Safety Network technical assistance and performing data analysis.

A VDH-developed toolkit of infection prevention resources for outpatient (ambulatory care) settings is now available on the VDH HAI website. To access it, click "Setting-Specific Resources" then "Ambulatory Care". Scroll down to "General Resources" and select "Infection Prevention Resources for Outpatient Settings".

Clostridium difficile Collaborative Webinar Recap

On November 28th, VHQC and VDH held a second webinar for facilities interested in joining the VHQC/VDH *Clostridium difficile* Infection Prevention Collaborative. This session focused on *C. diff* surveillance in the acute care and long-term care settings.

Kathy Bailey, Director of Infection Prevention from Centra Health, discussed *C. diff* surveillance definitions for acute care facilities and how to report *C. diff* LabID events using the National Healthcare Safety Network.

Jennifer Reece, HAI Team Lead at VHQC, outlined *C. diff* surveillance definitions for long-term care and introduced the reporting tool that will be used by collaborative participants.

Collaborative facilities will be submitting data to VHQC monthly (via NHSN for acute care and fax for long-term care). Dec 2012—Feb 2013 data will be the baseline period and March—Aug 2013 data will be the collaborative period.

The next webinar will be held on December 19th. Facilities will be sharing policies and practices so that the collaborative leadership will be able to help identify strengths and areas for improvement. The session will be open to collaborative participants only, so if your facility is interested, make sure you enroll soon! Working together, we can make a difference in our communities by reducing the rates of *C. diff* across Virginia.

VHQC's website (**www.vhqc.org/resource.asp**) has copies of the commitment forms and will soon also include a recording of the most recent webinar as well as the slides. If your facility has any questions about participating, please contact Amy Lenz at 804-287-0286. To enroll in the collaborative, scan, mail, or fax a completed commitment form by **12/14** to:

VHQC
Attn: Amy Lenz
9830 Mayland Dr., Suite J
Richmond, VA 23233
804.289.5324 (fax)   alenz@vaqio.sdps.org

In this issue:

Notes from VDH	1
C. difficile Webinar Recap	1
HAI Grantees' Meeting Summary	2
National Handwashing Awareness Week	2
SSI Surveillance Changes for 2013	3
Fungal Meningitis Outbreak Update	4
Get Smart About Antibiotics Week	4
New Resident Safety Tool for Nursing Homes	4
Norovirus Infection Prevention Tips	5
Bed Bugs in Healthcare	5

Upcoming Events:

December 2-8: National Handwashing Awareness Week

Dec 11, 10 AM: Surveillance Q&A conf call for long-term acute care hospitals and inpatient rehab facilities

Dec 14, close of business: Last day to enroll in the VHQC/VDH *C. diff* Collaborative

Contact:

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

HAI Grantees' Meeting Summary—November 7-8

On November 7th and 8th, the Healthcare-Associated Infections (HAI) Epidemiology and Laboratory Capacity for Infectious Diseases (ELC) Grantees' Meeting was held at the Centers for Disease Control and Prevention (CDC) in Atlanta, GA. State HAI Program Coordinators, CDC staff, and other representatives from state and national organizations met to update each other with information and technical guidance on state health department HAI prevention efforts.

Sessions covered a variety of topics including evaluating state HAI programs, communicating with policy makers, antimicrobial resistance, dialysis, *Clostridium difficile* infection prevention collaboratives, and using HAI data for action. Some highlights relevant to infection preventionists:

- Risk adjustment for reporting of *C. difficile* and MRSA bacteremia LabID events using the National Healthcare Safety Network (NHSN) was discussed. The *C. difficile* LabID standardized infection ratio (SIR) will adjust for facility bedsize, facility teaching status, CDI prevalence rate, and test type. The MRSA bacteremia SIR will adjust for facility bedsize, faciity teaching status, and MRSA prevalence rate.
- The next CDC "Vital Signs" report will feature Carbapenem-resistant Enterobacteriaceae as the topic. The last HAI-related Vital Signs was on *C. difficile* infection and was published in March 2012.
- CDC has updated its dialysis website, with new audit tools, protocols, and checklists (**www.cdc.gov/dialysis**).
- If your hospital merges units or opens a new unit, be sure to update your conferred rights for the necessary groups (e.g., VDH group rights if you open a new adult ICU).
- Potential reasons why Hospital Compare data may be different from your NHSN data:
  - ◊ Reporting plan is incomplete.
  - ◊ Inpatient procedure entered as outpatient procedure.
  - ◊ Data were updated after the "freeze date". CMS reporting deadlines are the 15th of Feb, May, Aug and Nov. Data are then frozen by CDC and sent to CMS. NHSN encourages data cleaning/updates but Hospital Compare data are *not* updated after the freeze dates.

The second day culminated with a training about a recently developed central line-associated bloodstream infection (CLABSI) validation toolkit. CDC has put together this toolkit with the goal of standardizing validation protocols across state health departments. CDC has been working with the Centers for Medicare and Medicaid Services (CMS) on their validation protocols and CMS has agreed (in concept) that state HAI data validation can be done by the states if a standardized method is established, maintained, and supported by CDC. The toolkit addresses both external and internal validation strategies. Stay tuned for an educational opportunity in early 2013 to learn more about ways to validate your facility's CLABSI data internally.

National Handwashing Awareness Week

According to CDC, the single most important thing we can do to keep from getting sick and spreading illness to others is to practice good hand hygiene. This simple step is an easy and effective tool that is applicable in all settings from home to healthcare facility. Mark your calendars for *National Handwashing Awareness Week*: **December 2-8, 2012**.

The Virginia Department of Health's HAI webpage has informational brochures, posters, and presentations for healthcare providers as well as the general public about this important topic. Please visit **www.vdh.virginia.gov/Epidemiology/Surveillance/HAI/HandHygiene.htm** for further information.

Additional resources to help spread the word and demonstrate proper hand hygiene practices may be found by visiting: **www.henrythehand.com/news-events/national-handwashing-awareness-week** and **www.cdc.gov/handwashing**

Clean Hands Save Lives!

Surgical Site Infection Surveillance Changes for 2013

Last month, we summarized some surveillance changes for January 2013 concerning new or updated key terms (present on admission, healthcare-associated infection, transfer rule, and device-associated). This month, we will highlight some changes to surgical site infection (SSI) surveillance definitions and protocols:

1) The definition of **primary closure will be changed** to include procedures where devices remain extending through the incision at the end of the surgical procedure.

"Primary closure is defined as closure of all tissue levels, regardless of the presence of wires, wicks, drains, or other devices or objects extruding through the incision. However, if there is nothing extruding from the incision but the skin edges are not fully reapproximated for the entire length of the incision (e.g., is loosely closed with gaps between suture/staple points), the incision is not considered primarily closed and therefore the procedure would not be considered an operation. In such cases, any subsequent infection would not be considered an SSI, although it may be an HAI if it meets criteria for another specific infection site (e.g., skin or soft tissue infection)."

2) **Duration of SSI surveillance** will no longer be determined by presence of surgical implant, nor type of SSI, but instead will be determined by the NHSN Procedure Category only. Thirty (30) or 90 day surveillance will be required as follows:

a) 30-day: AAA, AMP, APPY, AVSD, BILI, CEA, CHOL, COLO, CSEC, GAST, HTP, HYST, KTP, LAM, LTP, NECK, NEPH, OVRY, PRST, REC, SB, SPLE, THOR, THYR, VHYS, XLAP

b) 90-day: BRST, CARD, CBGB, CBGC, CRAN, FUSN, FX, HER, HPRO, KPRO, PACE, PVBY, RFUSN, VSHN.

3) NHSN will **no longer collect information on "implants"** utilized during operative procedures as part of SSI surveillance.

4) **NHSN Principal Operative Procedure Category Selection Lists in SSI manual chapter will be updated** to reflect more current NHSN SSI data. Main changes are: COLO will be higher than SB on the abdominal operations list; CRAN will be inserted after RFUSN on the NS (Spine) operations list; and RFUSN, FUSN, and LAM will be added to the NS (Brain) operations list as follows: VSHN, RFUSN, CRAN, FUSN, LAM.

5) Several **specific site criteria for organ/space SSI and for nonsurgical HAI events** (as found in Chapter 17 of the NHSN Patient Safety Component Manual) **will be updated** to change the criterion "Radiographic evidence of infection" to "Imaging testing evidence of infection" and change "Other evidence of infection found on direct exam, during surgery, or by diagnostic tests" to "Other evidence of infection found on direct exam, during invasive procedure, or by diagnostic tests". This will bring the definitions more in line with current diagnostic and treatment practices.

6) If a patient has a **documented infection present on admission (POA)* in the organ/space being operated on in the first 2-day period of hospitalization**, subsequent continuation of this infection type during the remainder of that hospitalization is **not considered an organ/space SSI**. However, if SSI becomes evident >2 calendar days after discharge** and within the surveillance period for the operative procedure, it is reportable as an organ/space SSI. If at any time during the surveillance period the incision becomes involved, report either superficial incisional or deep incisional SSI as appropriate. Note: A *Denominator for Procedure* form must still be completed for every procedure performed which is included in the operative procedure category under surveillance, regardless of POA status.

*POA infection: occurs on day of admission or next day and fully meets a CDC/NHSN site-specific infection criterion.

**Day of discharge is Day 1

Fungal Meningitis Outbreak Update

The Virginia Department of Health continues to work closely with the Centers for Disease Control and Prevention (CDC) on the multistate investigation of fungal meningitis and other infections among patients who received a methylprednisolone acetate (MPA) injection prepared by the New England Compounding Center (NECC) in Framingham, Massachusetts. Three recalled lots of steroid are implicated in the outbreak.

As of November 26, 2012, a total of 510 cases and 36 deaths have been reported in 19 states. Virginia has reported 51 cases and 2 deaths to date.

Exserohilum rostratum continues to be the predominant fungus identified in patients' specimens submitted to the CDC laboratory. This organism is a common mold found in soil and on plants. Thriving in warm and humid climates, *E. rostratum* has been noted to cause infections of the skin and the cornea, as well as more invasive infections in the sinuses. Infections in people are rare and cannot be transmitted from person-to-person.

For a detailed update of the current situation, case count maps, and further information from the CDC, please visit: **www.cdc.gov/hai/outbreaks/meningitis.html**.

Get Smart About Antibiotics Week

November 12-18 marked the CDC's 5th annual *Get Smart About Antibiotics Week*. This observance highlighted the safe and prudent use of antibiotics and was conducted in collaboration with CDC's national *Get Smart: Know When Antibiotics Work* campaign and state campaigns that included non-profit and for-profit partners.

As we enter cold and flu season, the CDC is hoping to spread the reminder that antibiotics are **not effective** against viral infections and may **increase** a person's risk for developing a future infection that is resistant to antibiotic treatment. Antibiotic resistance is considered among the world's most pressing public health threats and creates a large economic burden on the healthcare system.

During Get Smart Week, CDC's Safe Healthcare blog (**http://blogs.cdc.gov/safehealthcare**) included several posts about antibiotic stewardship that covered the following topics: drivers of appropriate antibiotic use in the inpatient settings; Extending the Cure – a policy research project aimed at extending antibiotic effectiveness; costs of antibiotic misuse; inappropriate antibiotic use in nursing homes; and *Clostridium difficile* infection.

The CDC Get Smart website features factsheets and tools addressing antibiotic use in healthcare settings across the spectrum of care. Please visit **www.cdc.gov/getsmart** for additional materials and information to help spread the word to others in your healthcare setting.

New Tool to Improve Safety of Care for Nursing Home Residents

The Department of Defense (DoD) and the Agency for Healthcare Research and Quality (AHRQ) have developed a TeamSTEPPS® tool set for the care of residents in long-term care settings. TeamSTEPPS is an evidence-based teamwork system that is aimed to improve patient/resident safety targeting strong communication and teamwork approaches that ultimately eliminate barriers to quality and safety.

The new tool set provides a source for ready-to-use materials for quality improvement projects in addition to a training curriculum allowing for the introduction of a successful program plan integrating teamwork principles among health care professionals. This version of TeamSTEPPS adapted for long-term care is available in DVD format and includes PowerPoint presentations and modules that can be used for staff education. Additional information, including how to order, may be found by visiting **www.ahrq.gov/TeamSTEPPStools/longtermcare**.

Norovirus Infection Prevention Tips

Norovirus is the most common cause of acute gastroenteritis and foodborne disease outbreaks in the United States. According to the CDC, norovirus causes about 21 million illnesses and contributes to about 70,000 hospitalizations and 800 deaths each year, mostly in young children and the elderly.

Although norovirus occurs throughout the year, over 80% of the outbreaks nationally occur from November to April. Virginia's syndromic surveillance data suggest that we may expect to see an increase in norovirus activity and outbreak reporting in the next few weeks, so it is important to be looking for the signs of norovirus within your facilities and notify your local public health department if you suspect an outbreak may be occurring.

The most common symptoms of norovirus are nausea, vomiting, diarrhea, and abdominal pain. Norovirus can spread easily in healthcare settings because only a small amount of the virus is necessary to get sick and the virus particles can be found in the stool before a person feels sick and for two weeks or more after you he or she feels better.

The CDC recommends simple steps to help prevent norovirus transmission:

- Practice proper hand hygiene
- Wash fruits and vegetables and cook seafood thoroughly
- When you are sick, do not prepare food or care for others
- Clean and disinfect contaminated surfaces.
- Wash laundry thoroughly

More information and updated resource guides from the CDC may be found by visiting **www.cdc.gov/norovirus/preventing-infection.html** or the main norovirus page (**www.cdc.gov/norovirus**).

Additional tools are also available on the VDH HAI website: **www.vdh.virginia.gov/Epidemiology/Surveillance/HAI/OtherInfections.htm**

Bed Bugs in Healthcare Settings

The November 2012 edition of *Infection Control and Hospital Epidemiology* features an article on bed bugs in healthcare settings. Actions to take upon identification of a bed bug are outlined, including what to do with the index case's clothing and belongings, inpatient or emergency department exam room, bed linens, and mattress/pillows. Guidance is also given for healthcare workers who have had contact with the index case as well as other patients who have been exposed.

Prevention strategies are emphasized, including:

- Train staff at points of entry (emergency or outpatient clinics) to recognize bed bugs and their bites.
- Avoid wood furniture and use plastic encasements for pillows and mattresses.
- Avoid fabrics for chairs, especially those in high-traffic areas such as emergency departments.
- Promptly respond *as soon as a bed bug is identified*, including closing infested rooms and placing all contaminated clothes and fabrics within sealed bags to help prevent the spread of bed bugs.
- Develop institutional policies that outline how to recognize bed bugs and their bites, who to notify, and how to treat the room and patient belongings to eradicate the infestation.

To access the article, go to:
www.jstor.org/stable/10.1086/668029

On a related note, on November 27th, a CDC Health Advisory was released to alert the public to an emerging national concern regarding misuse of pesticides to treat infestations of bed bugs and other insects indoors. Some pesticides are being applied indoors even though they are approved only for outdoor use. Even pesticides that are approved for indoor use can cause harm if over applied or not used as instructed on the product label. If you did not receive the Health Advisory, you can access it at:
http://emergency.cdc.gov/HAN/han00336.asp