SYNERGY: COMBINING EFFORTS FOR HAI PREVENTION

January 2012

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

Volume 3, Issue 1

Edited by: Andrea Alvarez

Notes from VDH

Congratulations to the Virginia Hospital & Healthcare Association and the North Carolina Hospital Association for being awarded a Hospital Engagement Network (HEN) contract by the Partnership for Patients. Four of the ten possible core areas of focus for the HEN-participating hospitals are HAIs. We look forward to hearing more about the HEN and the progress on its quality improvement efforts.

VDH recently learned that we have not received additional funding for the calendar year. With our current staffing levels, we want to continue to work with our partners by lending expertise, developing documents and training materials, making information available on our website, and participating in committees and discussions. Let us know how we can best continue to be a resource for you!

Guidelines for Safe Work Practices in Medical Diagnostic Laboratories

On January 6, 2012, the Centers for Disease Control and Prevention (CDC) released *Guidelines for Safe Work Practices in Human and Animal Medical Diagnostic Laboratories* in a supplement of the *Morbidity and Mortality Weekly Report* (MMWR). This report complements the 5th edition of *Biosafety in Microbiological and Biomedical Laboratories* (BMBL-5), published in 2009 by CDC and the National Institutes of Health.

A Blue Ribbon Panel of laboratory experts representing various facets of laboratory science was organized by the CDC in 2008 and charged with reviewing laboratory biosafety in diagnostic laboratories. The group recommended that science-based guidelines be developed addressing the unique operational needs for human and animal diagnostic laboratories. The *MMWR* supplement presents the guidelines developed by the panel of experts and spans various sections of laboratory science focusing on a culture of safety and the prevention of injuries in diagnostic laboratories. The report contains specific sections for veterinary diagnostic laboratories with associated guidelines for veterinary issues.

Contents of the report include sections which address: biological risk assessment and biosafety guidelines; fundamental biosafety practices and education; specific information for the individual functions and divisions within the laboratory setting; storing, packaging, and shipping of infectious substances; and emergency procedures and responsibilities.

Please view the complete report for specific information regarding the individual laboratory divisions and associated guidelines: **http://www.cdc.gov/mmwr/pdf/other/su6101.pdf**

In this issue:

Upcoming Events:

Jan 25 - CLABSI 2011Q1 data available on Hospital Compare website

Late February (tent.) - CDC releases 2010 state-specific and national SIR report

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

Expectations of VDH Mandatory Reporting

- On Tuesday, January 24th, an e-mail was sent to IPs and NHSN contacts explaining facility reporting expectations to meet the VDH mandate(s) for HAIs, which currently includes CLABSIs in acute care adult intensive care units
- E-mail includes: due dates for data (also in table below), checklists, tips, and references for future use
- After each quarter, all data should be entered by the end of the following month; two reminders will be sent, and data will be pulled on the 15th of the month after the data are due (see table)
- Common mistakes leading to noncompliance:
  - ◊ Not keeping the digital certificate up to date
  - ◊ Not completing the annual survey (the 2011 survey must be completed now to make 2012 monthly reporting plans)
  - ◊ Not creating monthly reporting plans each month (can copy from previous months)
  - ◊ Not entering a 0 denominator when applicable in the Summary Data
  - ◊ Not checking the "No Reported Events" box in the Summary Data

Quarter (months)	Entered into NHSN *before*	Reminders from VDH	Final data pulled
1 (Jan - Mar)	May 1st	May 5th and 10th	May 15th
2 (Apr - June)	August 1st	Aug 5th and 10th	Aug 15th
3 (July - Sept)	November 1st	Nov 5th and 10th	Nov 15th
4 (Oct - Dec)	February 1st	Feb 5th and 10th	Feb 15th

NHSN Question and Answer (Q&A) Corner

Q. Through the VDH/VHHA data validation project, VDH identified hospitals that were not counting the denominator correctly. If a hospital had been incorrectly reporting data into NHSN and they do not have the information to correct and update those past months, should they take those months out of their monthly reporting plan? Are there any negative impacts since the past NHSN reports would no longer have the same number of facilities reporting?

A. Yes, please have them remove the months with incorrect data from their monthly reporting plans. Even though it will affect the NHSN data, this is the more appropriate option.

Q. If a patient is simply located in the ICU because of overflow problems, but is located in and attended to by ICU staff, would the summary data of the patient be included in the ICU data ?

A. Yes, that is correct.

Q. How do I map a unit that does not consistently fit the 80% rule? This seems to be a common question for small facilities.

A If a patient care area has beds that are sometimes used for patients requiring intensive care, but are also used for patients receiving lower levels of care, do not call that location an ICU. It can be called a mixed acuity ward.

If a patient care area has beds that are used for patients requiring intensive care and are otherwise left empty when not in use, and these beds happen to be co-located in a patient care area with beds used for patients requiring lower levels of care, then these intensive care beds can be designated as an ICU. This is similar to how we handle a mixed ICU type (i.e., 10 bed ICU with 6 beds for trauma and 4 beds for surgery, this gets "split" into a TICU and a SICU). The reason for location designation is to have homogenous patient types in the same/similar location within different facilities. This produces reliable denominators and permits internal and external comparison. Please refer to the CMS website for specific requirements related to CMS's Hospital Inpatient Quality Reporting Program.

Influenza Updates

The January 6, 2012 edition of *Morbidity and Mortality Weekly Report* (**http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6051a1.htm**) includes an article on an outbreak of severe influenza in a residential facility for persons with neurologic and neurodevelopmental conditions. The findings highlight the importance of having and following an influenza outbreak management strategy that includes:

- influenza vaccination of residents and staff before an outbreak occurs
- influenza testing and surveillance among residents, staff, and visitors
- infection control measures
- prompt and aggressive use of influenza antiviral drugs for both treatment and prevention

Also, in December 2011, CDC posted consolidated influenza outbreak management guidance for long-term care facilities. For more information, go to: **www.cdc.gov/flu/professionals/infectioncontrol/ltc-facility-guidance.htm**

Successful Strategies Pre-Test/Post-Test Answers

Several attendees from the *Successful Strategies for Infection Prevention in Assisted Living Facilities and Nursing Homes* and *Successful Strategies...for Inspectors* trainings have asked VDH to share the answers from the pre-test/post-test. In general, the questions on defining an outbreak, levels of disinfection, and time period to exclude sick staff were missed most often.

Question: Standard precautions are only used whenever you are caring for a resident with a known infection and/or disease that can be transmitted to other residents or staff.

Answer: FALSE. Standard precautions are used in all situations, not just when caring for residents with a known infection/disease.

Question: An outbreak is defined as 3 or more people with a particular communicable disease.

Answer: FALSE. An outbreak is a higher than usual amount of disease activity; there is no set number of cases that defines an outbreak.

Question: Using a high-level disinfectant on critical care and non-critical care items protects residents because these disinfectants remove all microorganisms and spores.

Answer: FALSE. High-level disinfectants are used on critical care items; they do <u>not</u> remove spores. To remove spores, you need to use a sterilization process.

Question: What does the acronym "MDRO" stand for?

Answer: Multidrug-resistant organism

Question: For accurate analysis, it is important to collect a laboratory specimen in the proper container and keep it at room temperature.

Answer: FALSE. Not all specimens are supposed to be kept at room temperature; some must be refrigerated to make sure that the bacteria/viruses do not grow.

Question: Hand hygiene is so important that inspectors from licensing agencies are instructed to observe hand hygiene practices of staff during site inspections.

Answer: TRUE.

Question: Staff members with symptoms of any communicable disease should be excluded from work until at least 48 hours after symptoms resolve, without the use of medicines that treat the symptoms.

Answer: FALSE. The number of hours may vary depending on the type of communicable disease, and the duties of the staff member.

Question: When performing hand hygiene, it is equally effective to use soap and water *or* an alcohol-based hand rub for every disease.

Answer: FALSE. To properly prevent the transmission of some organisms and prevent the spread of disease, one specific form of hand hygiene is recommended. For example, for *Clostridium difficile*, it is recommended to wash hands with soap and water because alcohol-based hand rubs do not kill the spores.

Question: As an inspector, different infection control practices apply than if you were a usual visitor.

Answer: FALSE. The same infection control practices apply to all.

Family/Caregiver Educational Campaign

The Department of Health and Human Services' Office of Healthcare Quality and the Partnership for Patients recently released a campaign to educate family members and caregivers about healthcare-associated infections and the steps they can take to protect their loved ones. The WAVE campaign focuses on the following areas:

W: Wash Hands

A: Ask Questions

V: Vaccinate

E: Ensure Safety (not touching medical equipment unless necessary and working with healthcare providers to make sure catheters and other medical devices are clean and removed as soon as they are no longer needed)

Brochures, wallet cards, and posters are available electronically on the Partnership for Patients website (**http://www.healthcare.gov/compare/partnership-for-patients/resources/conditions.html#wave**).

National Quality Forum Measures—Public Comment Period Open

The National Quality Forum (NQF) develops harmonized consensus standards for healthcare quality measures and endorses pilot-tested healthcare quality measures.

A public comment period is open until February 3rd on its latest set of published measures, which includes 19 measures related to immunization and screening. One of the measures assesses influenza vaccination of healthcare personnel (HCP) in the following settings: acute care hospitals, ambulatory surgical centers, long-term care facilities, outpatient clinics, and renal dialysis centers.

The Centers for Medicare and Medicaid Services (CMS) gives preference to fully-endorsed NQF measures when considering measures for inclusion in its Hospital Inpatient Quality Reporting Program. Acute care hospitals participating in this program will be required to report HCP influenza vaccination rates using NHSN in January 2013 and ambulatory surgical centers will be required to report using the same system starting October 2014.

Three groups of healthcare personnel are considered: employees, licensed independent practitioners, and adult students/trainees, and volunteers. Vaccination status is calculated separately for each of the three categories. Healthcare personnel must work 30 or more days during the influenza season to be included in the measure.

To read the full definition of the healthcare personnel vaccination measure, post a comment (before Feb 3), or obtain information about other proposed measures, go to: **http://www.qualityforum.org/Projects/n-r/Population_Health_Prevention/Population_Health__Prevention_Endorsement_Maintenance.aspx?section=PublicandMemberComment2012-01-052012-02-03**

Norovirus Outbreak Control Resource Toolkit

To supplement the 2011 Healthcare Infection Control Practices Advisory Committee (HICPAC) Guideline for the Prevention and Control of Norovirus Gastroenteritis Outbreaks in Healthcare Settings, the Centers for Disease Control and Prevention (CDC) recently developed a norovirus outbreak control resource toolkit for healthcare settings.

The new norovirus toolkit features recommended infection control measures and tools for outbreak response, coordination, and reporting. Toolkit components include:

- An overview of the toolkit
- A poster on what healthcare providers should know
- A fact sheet about norovirus in healthcare settings
- A sample communication framework for suspected or confirmed outbreaks
- A worksheet to track gastrointestinal illness/norovirus cases
- Key infection control recommendations
- A sample specimen submission framework for use during norovirus outbreaks
- A slide set on the management of norovirus outbreaks

The toolkit is available electronically on the CDC norovirus website: **http://www.cdc.gov/HAI/organisms/norovirus.html**

CDC CLINICAL REMINDER

Insulin Pens
Must Never Be Used for More than One Person

Summary

The Centers for Disease Control and Prevention (CDC) has become increasingly aware of reports of improper use of insulin pens, which places individuals at risk of infection with pathogens including hepatitis viruses and human immunodeficiency virus (HIV). This notice serves as a reminder that insulin pens must **never** be used on more than one person.

Background

Insulin pens are pen-shaped injector devices that contain a reservoir for insulin or an insulin cartridge. These devices are designed to permit self-injection and are intended for single-person use. In healthcare settings, these devices are often used by healthcare personnel to administer insulin to patients. Insulin pens are designed to be used multiple times, for a single person, using a new needle for each injection. Insulin pens must **never** be used for more than one person. Regurgitation of blood into the insulin cartridge can occur after injection [1] creating a risk of bloodborne pathogen transmission if the pen is used for more than one person, even when the needle is changed.

In 2009, in response to reports of improper use of insulin pens in hospitals, the Food and Drug Administration (FDA) issued an alert for healthcare professionals reminding them that insulin pens are meant for use on a single patient only and are not to be shared between patients [2]. In spite of this alert, there have been continuing reports of patients placed at risk through inappropriate reuse and sharing of insulin pens, including an incident in 2011 that required notification of more than 2,000 potentially exposed patients [3]. These events indicate that some healthcare personnel do not adhere to safe practices and may be unaware of the risks these unsafe practices pose to patients.

Recommendations

Anyone using insulin pens should review the following recommendations to ensure that they are not placing persons in their care at risk for infection.

- Insulin pens containing multiple doses of insulin are meant for use on a single person only, and should **never** be used for more than one person, even when the needle is changed.
- Insulin pens should be clearly labeled with the person's name or other identifying information to ensure that the correct pen is used **only** on the correct individual.
- Hospitals and other facilities should review their policies and educate their staff regarding safe use of insulin pens and similar devices.
- If reuse is identified, exposed persons should be promptly notified and offered appropriate follow-up including bloodborne pathogen testing.

These recommendations apply to any setting where insulin pens are used, including assisted living or residential care facilities, skilled nursing facilities, clinics, health fairs, shelters, detention facilities, senior centers, schools, and camps as well as licensed healthcare facilities. Protection from infections, including bloodborne pathogens, is a basic expectation anywhere healthcare is provided. Use of insulin pens for more than one person, like other forms of syringe reuse [4], imposes unacceptable risks and should be considered a 'never event'.

See additional information on assuring safe care during blood glucose monitoring and insulin administration.

References

1. Sonoki K, Yoshinari M, Iwase M, Tashiro K, Iino K, Wakisaka M, Fujishima M. Regurgitation of blood into insulin cartridges in the pen-like injectors. Diabetes Care. 2001;24(3):603-4.
2. Information for healthcare professionals: risk of transmission of blood-borne pathogens from shared use of insulin pens (2009). U.S. Food and Drug Administration Postmarket Drug Safety Information for Patients and Providers.
3. Important Patient Safety Notification (2011). Dean Clinic.
4. Centers for Disease Control and Prevention (CDC) and the Safe Injection Practices Coalition (SIPC).

National Center for Emerging and Zoonotic Infectious Diseases
Division of Healthcare Quality Promotion (DHQP)

This reminder was issued in early January.

For more information, go to CDC's injection safety website: http://www.cdc.gov/injectionsafety/blood-glucose-monitoring.html