

# 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

Thanks to all of you who commented on the proposed amendments to the healthcare-associated infections reporting regulations. We are summarizing the comments now and will keep you updated about the process as we decide how to move forward.

## NHSN Notes

The Centers for Disease Control and Prevention (CDC) and 10 state health departments that participate in the Emerging Infections Program are engaged in a project to evaluate the use of a simplified, less resource-intensive method of denominator data collection for central line-associated bloodstream infections (CLABSI) surveillance using the National Healthcare Safety Network (NHSN). The project seeks to

Assisted living facility and nursing home staff—please remember to register for a **FREE** training on infection prevention. To find the date and location in your region and information on how to register, please visit: <http://www.vdh.virginia.gov/Epidemiology/Surveillance/HAI/ANRresources.htm>

evaluate the validity and feasibility of using a sampling method (collecting data one day a week instead of every day) to obtain an estimate of central line days to calculate the CLABSI rate. If found to be valid, adopting a once-weekly sampling method could result in an 85% reduction in staff time required to collect CLABSI denominator data. Phase 2 of the project began in January 2011. CDC will share updates as they become available.

## Evolving Uses of HAI Data

In the March edition of the *American Journal of Infection Control*, the APIC president and a CDC representative from Division of Healthcare Quality Promotion (DHQP) discussed renewed challenges to older concerns regarding HAI data. While HAI data originally were and still are used for surveillance and internal quality improvement activities, newer uses including pay-for-reporting programs and interfacility comparisons, have suddenly heightened the debate and demand for solutions.

The article entitled “Meaningful measure of performance: a foundation built on valid, reproducible findings from surveillance of healthcare-associated infections” points to many of the competing issues including

credible data vs. reporting burden, surveillance definition vs. clinical definition, variability in patient population and surveillance resources vs. comparability, and transparency of internally collected HAI data vs. providing data only on preventable infections.

NHSN has been working to address some concerns by creating a Steering Working Group, providing educational and training opportunities, and developing more automated systems to increase validity and decrease burden. CDC, APIC, and state health departments will continue to support infection prevention and work to develop some solutions.

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### Upcoming Events:

May 10/11, 24/25,  
June 1/2, 15/16, 29/30:  
Infection prevention training for assisted living facilities and nursing homes (various locations)

May 20, 2011:  
CLABSI training (webinar)

June 23, 2011:  
Field Epi Seminar  
(Richmond, VA)

### Contact:

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

## Partnership for Patients

On April 12, the Obama Administration launched the **Partnership for Patients: Better Care, Lower Costs**, a new public-private partnership aimed to help improve the quality, safety, and affordability of health care for all Americans.

Up to \$1 billion in new funding for this initiative will be provided by the Affordable Care Act. Stakeholders across the continuum of care, including physicians, nurses, hospitals, health plans, employers, patients, and their advocates, will be engaged to accomplish two goals:

- **Prevent harm:** The Partnership for Patients aims to keep patients from getting injured or sicker. This means decreasing preventable healthcare-associated infections by 40% and preventing approximately 1.8 million injuries by the end of 2013. To accomplish this, the Innovation Center at the Centers for Medicare and Medicaid Services (CMS) will be apportioning up to \$500 million to study different models that will improve the care of patients and patient collaboration. The findings from the model testing will be used to help hospitals create “effective, evidence-based care improvements to target preventable patient injuries.”

## Electronic Faucets: Friends or Foes?

A recent study conducted at the Johns Hopkins School of Medicine resulted in the discovery that electronic hands-free faucets are more likely than manual faucets to grow high levels of bacteria. The study analyzed bacteria found from 20 manual faucets and 20 electronic faucets in two clinical wards that received water from the same source.

## New England Journal of Medicine Hand Hygiene Video

Hand hygiene is the cornerstone to infection prevention. If your facility is looking for an educational tool to review the basics of hand hygiene, consider checking out this video from the New England Journal of Medicine. It can be downloaded free of charge and covers hand hygiene techniques, hand hygiene equipment, appropriate use of

**Improve care transitions:** The Partnership for Patients also seeks to decrease the number of hospital readmissions by 20% by the end of 2013. This equates to more than 1.6 million patients recovering from illness without suffering a preventable complication requiring readmission within 30 days of discharge. To accomplish this, up to \$500 million will be provided by the Community-Based Care Transition Program at CMS to fund and fuel partnerships between community-based organizations and qualified hospitals for transitional care services, including medication review and management and patient-centered self-management support after discharge. Eligible community-based organizations and acute care hospitals that partner with community-based organizations can apply for funding and learn more at: [www.cms.gov/DemoProjectsEvalRpts/MD/itemdetail.asp?itemID=CMS1239313](http://www.cms.gov/DemoProjectsEvalRpts/MD/itemdetail.asp?itemID=CMS1239313)

Stakeholders including hospitals and healthcare organizations, patient and consumer organizations, and employers, unions, and health plans are encouraged to sign a pledge to commit to this partnership.

For more information, please visit: [www.healthcare.gov/center/programs/partnership/index.html](http://www.healthcare.gov/center/programs/partnership/index.html)

Half of electronic faucets grew *Legionella spp.*, compared to 15% of the manual faucets. Even after cleaning the faucets with chlorine dioxide, commonly used in water treatment and in bleaching, 29% of electronic faucets were still contaminated with some type of bacteria while only 7% of manual faucets were contaminated. These findings created concern for the researchers because the levels of bacterial growth were higher than the usual thresholds in place by the hospital.

gloves, policies on jewelry and fingernail hygiene, selected complications such as skin irritation and fire hazards, and religious issues.

To access the video, please visit:  
<http://www.nejm.org/doi/full/10.1056/NEJMvcm0903599>

## New Guidelines to Prevent Intravascular Catheter-Related Infections

On April 1, new guidelines for the prevention of intravascular catheter-related bloodstream infections were published by the Centers for Disease Control and Prevention (CDC) and the Healthcare Infection Control Practices Advisory Committee (HICPAC). These new evidence-based guidelines replace the guidelines published in 2002 and can be found on either the CDC's HICPAC website (<http://www.cdc.gov/hicpac/BSI/BSI-guidelines-2011.html>) or in the April 1<sup>st</sup> edition of the journal *Clinical Infectious Diseases*.

Areas of emphasis of the guidelines include:

- Educating and training personnel who insert and maintain catheters
- Using maximal sterile barrier precautions during central venous catheter insertion
- Using a >0.5% chlorhexidine skin preparation with alcohol for antisepsis
- Avoiding routine replacement of central venous catheters to prevent infection
- Using antiseptic/antibiotic impregnated short-term central venous catheters and chlorhexidine impregnated sponge dressings if the infection rate is not decreasing despite adherence to other prevention strategies
- Implementing quality improvement strategies such as the use of bundles and documenting and reporting rates of compliance with all components of the bundle

## Clinical Reminder on Facemask Use During Spinal Injection Procedures

In response to recent outbreaks of bacterial meningitis in patients undergoing spinal injection procedures, the Centers for Disease Control and Prevention (CDC) issued a clinical reminder for healthcare providers on the recommended infection prevention strategies to ensure patients are not placed at risk for infections when undergoing a spinal injection procedure.

Facemasks are to be used when injecting material or inserting a catheter into the epidural or subdural space (e.g., myelogram, administration of spinal or epidural anesthesia, or intrathecal chemotherapy). Aseptic

technique and safe injection practices (such as the use of a single-dose vial of medication for a single patient) should always be followed for all spinal injection procedures.

The use of facemasks for these procedures is considered a component of standard precautions. It is important to remember that these recommendations apply to all settings where spinal injection procedures are performed, not only in acute care settings.

For more information, please visit: [http://www.cdc.gov/injectionsafety/PDF/Clinical\\_Reminder\\_Spinal-Infection\\_Meningitis.pdf](http://www.cdc.gov/injectionsafety/PDF/Clinical_Reminder_Spinal-Infection_Meningitis.pdf)

## World Health Day

World Health Day (April 13<sup>th</sup>) stimulated the collaboration of CDC, the World Health Organization, and other health-related organizations to shine the spotlight on antimicrobial resistance. Antimicrobial-resistant organisms are becoming a more pressing issue of public health significance due to the inappropriate use and overuse of antibiotics in healthcare settings. Resistance limits treatment options, can lead to a higher risk of patient complications, and poses a significant economic burden on the healthcare system. To address this issue, an interagency task force drafted a document entitled *A Public Health Action Plan to Combat Antimicrobial*

*Resistance*. This plan describes four focus areas (surveillance, prevention, research, and product development) and outlines action items that can be taken toward reducing antimicrobial resistance. The take-home message is that sustained effort, commitment, and collaboration of a spectrum of stakeholders from patients to policymakers is essential to monitor, prevent, and control antimicrobial resistance.

To view the action plan, visit: <http://www.cdc.gov/drugresistance/pdf/2010/Interagency-Action-Plan-PreClearance-03-2011.pdf>