SYNERGY: COMBINING EFFORTS FOR HAI PREVENTION

May 2012

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

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Notes from VDH

Don't forget to register for upcoming trainings! VDH, VHQC, and the Virginia Hospital & Healthcare Association (VHHA) all have exciting educational opportunities planned for June! Details can be found on page 6 for the VDH Field Epidemiology Seminar that will be held on June 27th at the Holiday Inn Koger Center in Richmond.

New to the VDH HAI website in May: Webinar archives/slide sets from SIR 101 and SIR 201 (see article below)

Last month, we mentioned that the *National Action Plan to Prevent HAIs: Roadmap to Elimination* has been updated to include ambulatory surgical centers, dialysis facilities, and healthcare personnel vaccination for influenza. As a reminder, the public comment period on the new plan will be open until June 25th.

To read the plan: **www.hhs.gov/ash/initiatives/hai/actionplan/index.html**

To submit your comments, e-mail: **OHQ@hhs.gov**

SIR 101 and 201 Webinars Archived and Now Available Online

In response to a request by an infection preventionist (IP), the VDH HAI Program conducted a two-part webinar series on the standardized infection ratio (SIR) on April 19th and May 3rd for infection preventionists and health department staff.

SIR 101 reviewed the SIR measure, how it is interpreted, and how it is being used and displayed by the National Healthcare Safety Network (NHSN), the Centers for Medicare and Medicaid Services (CMS), and the Virginia Department of Health. Bonita Allen, IP from Parham Doctors' Hospital, shared her experience and success in starting to educate and expose her staff to the SIR. The webinar also reviewed the importance of statistical significance when working with data.

SIR 201 was a nuts and bolts review of how the SIR is derived for central line-associated bloodstream infections (CLABSIs) and surgical site infections (SSIs), how to generate and modify NHSN SIR reports, and how to use NHSN data quality tools to ensure SIR data are complete and in compliance with reporting requirements. It is the HAI Program's hope that the webinar slides will be a helpful step-by-step tool to help facilities not only meet their compliance requirements, but also assist in transforming the entered data into useful metrics that can be shared with staff and administrators.

SIR 101 and 201 slide sets and webinar recordings are available on the VDH HAI website (Communications and Education page) under "Past Training Opportunities" at: **www.vdh.virginia.gov/epidemiology/surveillance/hai/communication.htm**.

In this issue:

Upcoming Events:

June 12-13: North Carolina/Virginia Hospital Engagement Network Conference, Richmond

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

Outbreaks of HBV Related to Blood Glucose Monitoring in ALFs—Virginia, 2009-2011: *MMWR* Article Summary

In conjunction with Hepatitis Awareness Month, VDH and CDC published an article in the *Morbidity and Mortality Weekly Report* (*MMWR*) on May 18th: "Multiple Outbreaks of Hepatitis B Virus (HBV) Infection Related to Assisted Monitoring of Blood Glucose Among Residents of Assisted Living Facilities (ALFs)—Virginia, 2009-2011." The article highlights the risk for hepatitis B transmission resulting from lapses in infection control practices during assisted blood glucose monitoring (BGM) and identifies strategies to protect susceptible residents to prevent future outbreaks. The article emphasizes the role of hepatitis B surveillance in detecting disease outbreaks and the need for a comprehensive strategy to prevent HBV transmission in ALFs, including vaccination, improved infection control oversight, appropriate training of staff members performing assisted BGM, and prompt investigation of acute HBV infections.

Although most Virginia outbreaks are identified by astute facility staff who recognize and report an increase in disease activity from baseline, sometimes health department staff identify a potential outbreak by reviewing individual disease case reports. The following describes the steps taken by the health department and the facilities to halt the spread of acute hepatitis B during these four documented outbreaks.

1. Initial acute hepatitis B virus infections were identified through routine viral hepatitis surveillance
2. VDH conducted epidemiologic and laboratory investigations of these reports
3. Infection control practices were assessed through direct observations and staff member interviews, especially assisted blood glucose monitoring practices
4. Subsequent screening of residents uncovered additional acute HBV infections at each ALF (total of 31 cases)
5. All acute HBV infections were among residents receiving assisted blood glucose monitoring
6. VDH provided recommendations to increase awareness and compliance with appropriate assisted BGM practices

Special thanks to the local and regional health department epidemiologists who not only identified and investigated these outbreaks and worked tirelessly with the assisted living facilities, but also published the information to help other states prevent similar outbreaks. These individuals include Jessica Watson from Henrico, Okey Utah and Yeatoe McIntosh from Richmond City, and Angela Myrick-West from the Central Region. To read the article, go to: **www.cdc.gov/mmwr/pdf/wk/mm6119.pdf**

May is Hepatitis Awareness Month

On May 19th, CDC's Division of Viral Hepatitis observed Hepatitis Testing Day as part of Hepatitis Awareness Month. To celebrate the month, several resources are available on the CDC website including an educational campaign called *Know More Hepatitis* and a brief online risk assessment: **www.cdc.gov/hepatitis/HepAwarenessMonth.htm**

A free Medscape activity for frontline care providers involved in the care of patients who have or are at risk for hepatitis B infection describes the "silent epidemic" of chronic HBV infection. The purpose of this short training is to increase awareness of the clinical and public health consequences associated with failure to screen for HBV infection, highlight the role care providers play in preventing disease transmission, and educate clinicians about the current HBV screening and vaccination guidelines (**www.medscape.org/viewarticle/759762**).

CDC also recently published a summary of outbreaks of healthcare-associated HBV or hepatitis C virus (HCV) infections that have occurred in the United States from 2008-2011. A total of 31 outbreaks were reported during this time period; 94% of these (n=29) occurred in non-hospital settings. Most HBV outbreaks occurred in long-term care (79%, n=15) while most HCV outbreaks occurred in outpatient settings (54%, n=7) or hemodialysis settings (38%, n=5). To view details about the hepatitis outbreaks: **www.cdc.gov/hepatitis/Outbreaks/HealthcareHepOutbreakTable.htm**

2011 Hospital Survey Results Suggest Updates Needed for Vaccination Policies

Ensuring healthcare personnel (HCP) and patients have the vaccinations they need for optimum disease protection is a critical part of HAI prevention efforts. Results from a recent VDH survey suggest that while many hospitals have vaccination recommendations in place, others may lack policies that promote protection. Two new VDH webpages feature tools to help address these potential gaps in vaccination policy.

Last October (2011), VDH's Division of Immunization (DOI) conducted a Hospital Survey on Influenza and Tdap (tetanus, diphtheria, and acellular pertussis vaccine) Vaccination Policies for the Health Commissioner's Pertussis Prevention Task Force. A survey tool was sent via email to 85 infection preventionists (IPs) in acute care, critical access, and children's hospitals throughout Virginia. The response rate was 36.5%, with respondents from a range of small to large hospitals across the state.

When asked about influenza vaccination policies for HCP with direct patient contact, 71% of respondents indicated they had a written recommendation, 22.6% indicated they had a mandatory influenza vaccination policy and 6.4% answered they did not have a policy.

When asked about the type of Tdap vaccination policy for HCP with direct patient contact in various high-risk settings, such as emergency departments (EDs) and neonatal intensive care units, most hospitals (64-80%) indicated they had a written recommendation for Tdap, with smaller percentages having either no policy (10.5-22.6%) or a mandatory vaccination policy (5.0-18.2%).

Among hospitals with EDs, 64.5% indicated they currently use Tdap vaccine for tetanus prophylaxis in wound management; 35.5% primarily use Td (tetanus and diphtheria vaccine). Approximately 63% of hospitals with labor and delivery (L&D) departments indicated they had Tdap standing orders for vaccinating postpartum women. Since the survey was conducted, CDC has published recommendations to vaccinate pregnant women with Tdap in the third or late second trimester (if no prior Tdap dose), or alternatively, immediately postpartum.

Based on the results of this survey, VDH encourages hospitals to review their current vaccination policies for HCP and patients, and consider updates based on the latest recommendations from CDC. Influenza vaccine is recommended for everyone 6 months of age and older every year. Tdap vaccine is recommended for all adults 19 years and older, especially those with direct patient contact and infant close contact.

Thanks to all those IPs who participated in the survey. DOI is considering conducting a follow-up survey this fall. The following links are for webpages that may help your facility update its vaccination policies.

For information on Tdap vaccination, see VDH's Pertussis Prevention webpage at: **http://www.vdh.virginia.gov/epidemiology/Immunization/Pertussis/index.htm**

For information on vaccinations recommended for HCP, see: **http://www.vdh.virginia.gov/epidemiology/Immunization/HCPersonnel/index.htm**

Infection Preventionist Competency White Paper

The May 2012 issue of the *American Journal of Infection Control* (AJIC) features a white paper titled "Competency in Infection Prevention: A Conceptual Approach to Guide Current and Future Practice" that is intended to serve as the basis for assessing the skills and knowledge base of the infection preventionist (IP) in different career states from novice to expert. This aligns with the Association for Professionals in Infection Control and Epidemiology (APIC) 2020 Strategic Plan advancing towards its vision "healthcare without infection" and the mission of creating a "safer world through prevention of infection".

Six core competencies defined by the Certification Board of Infection Control and Epidemiology (CBIC) form the basis for the model. APIC describes the four domains of competencies required for strategic development to advance an IP's career from novice to expert. These domains are leadership, infection prevention and control, technology, and performance improvement and implementation science. Noted within the paper is emphasis on the achievement of Certification in Infection Control (CIC) as a measure of validation for the IP's competency.

To access the white paper and learn more about the IP competencies: **http://www.ajicjournal.org/article/S0196-6553(12)00165-4/fulltext**

Safe Injection Practices: CDC Position Statement Regarding Single-Dose/Single-Use Vials and Toolkit for Local/State Health Departments

In early May, the Centers for Disease Control and Prevention (CDC) restated its position regarding the importance of protecting patients against preventable harm from the **improper use of single-dose/single-use vials**.

This statement was created in response to ongoing questions and misinformation about CDC's injection safety guidance. A recent document circulated by the American Society of Interventional Pain Physicians may be causing confusion among clinicians.

The complete CDC position statement can be accessed at: **www.cdc.gov/injectionsafety/CDCposition-SingleUseVial.html**

Some of the take-home messages are outlined below for your convenience:

◊ Vials labeled by the manufacturer as "single-dose" or "single-use" should only be used for a **single patient**. These medications typically lack antimicrobial preservatives and can become contaminated and serve as a source of infection when they are used inappropriately.

◊ Ongoing **outbreaks** provide ample evidence that inappropriate use of single-dose/single-use vials causes patient harm.

◊ Since the CDC safe injection practices guidelines were published in 2007, CDC is aware of at least 26 outbreaks due to unsafe injection practices.

- These outbreaks resulted in more than **95,000** patients being referred for testing after potential exposure to infectious diseases.
- Nearly three-fourths (73%, n=19) of these outbreaks involved use of single-dose/single-use medications for more than one patient.
  - All of the outbreaks associated with improper use of single-dose/single-use medications occurred in **outpatient settings**, with pain clinics (n=8, 42%) representing the most common facility type.

◊ In times of critical need, contents from unopened single-dose/single-use vials **can be** repackaged for multiple patients. However, this should **only** be performed by qualified healthcare personnel in accordance with standards in United States Pharmacopeia (USP) General Chapter 797, Pharmaceutical Compounding – Sterile Preparations. Even if a single-dose or single-use vial appears to contain multiple doses or contains more medication than is needed for a single patient, that vial should not be used for more than one patient nor stored for future use on the same patient. Healthcare facilities can proactively arrange for these doses to be split, in accordance with USP standards, when necessary.

◊ Lowering safety standards **will not** address the problem of drug shortages, which are a result of manufacturing, shipping, and other issues unrelated to the above guidelines (**www.fda.gov/DrugShortageReport**).

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In addition, earlier this year, the Safe Injection Practices Coalition (SIPC) released a state/local health department injection safety toolkit to share the lessons learned from three states (Nevada, New Jersey, and New York) that have implemented the *One & Only Campaign* to disseminate safe injection practices messaging to healthcare providers and the general public. The toolkit contains information to provide an overview of the economic and emotional impacts of unsafe injection practices, help build a working group, develop partnerships, and use the media/press.

www.oneandonlycampaign.org/content/statelocal-health-department-toolkit

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For more information on safe injection practices:

◊ CDC Injection Safety website
www.cdc.gov/injectionsafety

◊ Safe Injection Practices Coalition website
www.oneandonlycampaign.org

◊ VDH HAI Program's Safe Injection Practices website
www.vdh.virginia.gov/epidemiology/surveillance/hai/SafeInjection.htm

HHS/APIC/SHEA HAI Prevention Award

The U.S. Department of Health and Human Services (HHS) has partnered with the Association for Professionals in Infection Control and Epidemiology (APIC) and the Society for Healthcare Epidemiology of America (SHEA) to create the *Partnership in Prevention Award.* This award will highlight and promote the work of one hospital team that has achieved sustainable improvements based on the National Action Plan to Prevent HAIs: Roadmap to Elimination and is helping to achieve the goals outlined by the HHS Partnership for Patients.

You are invited to nominate your team! More information on application instructions and eligibility criteria is available here: **www.hhs.gov/ash/initiatives/hai/projects/partner-prevention-eligibilitycriteria.pdf**

Nominations will be accepted through August 1st and the award will be given on October 15th during International Infection Prevention Week.

Questions may be directed to **awards@apic.org**.

NHSN Q&A / Updates on the Latest Version of NHSN

Q. If I add any units in NHSN, does NHSN automatically update the "Confer Rights—Patient Safety Page" to include the new units?

A. No, NHSN does not automatically update the "Confer Rights—Patient Safety Page" to include new units. You must manually make the changes. To do this, log into NHSN, click "Group" then "Confer Rights" on the blue navigation bar. Highlight VDH and click the "Confer Rights" button and "OK". Scroll down to "Infections and other Events", click on the "Your Locations" drop down menu and check the appropriate boxes. Do not uncheck inactivated units. Do the same for "Summary Data for Events". Make sure to click "Accept" at the bottom of the page. If you would like verification that VDH can now see your new units, please e-mail Dana.Burshell@vdh.virginia.gov.

Q. Am I in compliance with CMS if I enter my summary data CLABSI and CAUTI denominators and I have no events?

A. To be in compliance with CMS, if you do not have any CLABSI or CAUTI events, your summary data are not complete without checking the "No Events" box. When the VDH HAI team conducted quality checks for the 2012Q1 CLABSI data earlier this month, nearly one-fourth of facilities had not checked the "No Events" box for at least one month and were therefore not in compliance. Please double check and resolve this issue if this applies to your facility.

Q. How many facilities are now using NHSN?

A. Nationwide, just over 8,800 facilities are currently using NHSN. Acute care facilities still represent the largest group (4,350), followed by dialysis facilities (3,781), long-term acute care hospitals (285), ambulatory surgery centers (223), inpatient rehabilitation facilities (154), and long-term care facilities (26).

NHSN v6.6.1 Updates

At the end of April, NHSN v6.6.1 was released and the Release Notes of all components are located at **www.cdc.gov/nhsn/commUp.html**.

Changes to the Patient Safety Component are summarized here:

- ◊ A new analysis output option called "SIR—Complex 30-Day SSI Data for CMS IPPS" was created.
- ◊ Dialysis Event reporting
  - Updated baseline rates and analysis output options
- ◊ Required updates for inpatient rehab locations in acute care facilities (also available for critical access hospitals)
  - Only applies to units who have an 'R' or 'T' in the 3rd position of their CMS Certification Number (CCN), so check the CCN with the billing/ administrative department(s) at your facility prior to changing location set-up.
  - Examples and step-by-step instruction available in the NHSN v6.6.1 Release Notes

VDH VIRGINIA DEPARTMENT OF HEALTH
Protecting You and Your Environment

Field Epidemiology Seminar 2012

Wednesday, June 27th
9:30am-4:30pm
(Registration begins at 8:30am)
Coffee and lunch will be provided

QUESTIONS?
CONTACT:
SETH LEVINE AT VDH
804-864-8116
OR EMAIL
SETH.LEVINE@VDH.VIRGINIA.GOV

Our seminar location is...

Holiday Inn
KOGER CONFERENCE CENTER

1021 Koger Center Blvd.
Richmond, VA 23235

A full day of presentations about outbreaks and other public health projects in Virginia

Topics include:

Tularemia, Salmonellosis, Group A Streptococcal Infection, Infant Botulism....and MANY MORE!!!
15 presentations in all!!
CME credits are requested!

Registration is online through TRAIN *Virginia:*

Course ID is 1033566

https://va.train.org/

You will need to login on the **TRAIN** site. If you have not been into the site yet, it may take a few minutes to create an account. (This is a one time entry- subsequent visits will only require your login name and password.)

If you have an account and have forgotten your password, or you encounter any problems during the registration process, please email robert.bradley@vdh.virginia.gov or call 804-864-8233.