SYNERGY: COMBINING EFFORTS FOR HAI PREVENTION

July 2012

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

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Edited by: Andrea Alvarez

Farewell from Dana, our HAI Epidemiologist

Dear colleagues/friends,
It has been a wonderful opportunity to work with you to help prevent healthcare-associated infections in the Commonwealth of Virginia. Just over 2.5 years ago, I arrived at the health department as a fellow and the first official member of the VDH HAI Team, and now I am leaving a well-established, successful program immersed in the infection prevention community.

I am off to start another chapter of my life in Charleston, SC. I can only hope that I will be surrounded by such dedicated, passionate, and collaborative colleagues. Fingers crossed.

Thank you to all for your partnership, your open-mindedness, and for sharing your ideas, experiences, and stories with me. I hope I was able to positively contribute to help support infection preventionists, long-term care providers, and healthcare consumers.

Knowing I would be leaving, Andrea and Carol have been cross-trained and will continue supporting your NHSN and epi needs. Yes, they are amazing! I look forward to hearing about Virginia's ongoing successes in infection prevention!

- Hugs and best wishes, Dana Burshell

Upcoming Educational Opportunities

Don't miss out on two great educational opportunities coming up!

On **August 21st** in Richmond at the Holiday Inn Koger Center, the Virginia Health Care Association (VHCA) will be holding an educational session on the prevention, identification, and treatment of urinary tract infections (UTIs) in long-term care.

Attendees will acquire knowledge of how residents are placed at risk when they receive unnecessary antibiotics, examine the regulatory perspective of UTIs and guidance to surveyors, review tools, protocols, and best practices for UTI prevention, and more!

To register and view more information about presenters and topics addressed:

www.vhca.org/events/20120821event.asp

In September, the Virginia chapter of the Association for Professionals in Infection Control and Epidemiology (APIC-VA) will be holding a pre-conference workshop on construction in healthcare prior to their two-day annual educational conference. Topics address issues across the continuum of care.

When:

Sept 19th: Pre-conference

Sept 20-21st: Annual educational conference

Where:

The Mason Inn Conference Center

Fairfax, VA

Questions? Need more information on speakers and registration?

http://apic-va.com/Education.html

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Upcoming Events:

Aug 21: VHCA Educational Session on UTIs in Long-Term Care, Richmond
Sept 19: APIC-VA Pre-Conference on Construction in Healthcare, Fairfax
Sept 20-21: APIC-VA Annual Educational Conference, Fairfax

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Hospital IP - Health Department Relationships, 2011

A survey was developed by APIC and the Council of State and Territorial Epidemiologists (CSTE) to gain a better understanding of the relationship between local health departments (LHDs), state health departments (SHDs) and hospital infection preventionists (IPs). The survey was distributed electronically to IPs in May of 2011. National results were published in the June 2012 *AJIC* and Virginia results were shared with the VDH HAI Program. Forty-eight IPs from Virginia responded, representing over half (58%) of Virginia's hospitals.

After reviewing the results from Virginia IPs, some areas for improvement were identified that will be shared with the IP community, LHDs, and the SHD so they can be better addressed.

◊ About one-third of respondents reported that Virginia did not have a specific law requiring public reporting of HAIs that had begun by May of 2011. *This is surprising because CLABSI reporting has been required by law since July of 2008.*

◊ Over one-fifth of responding IPs did not think or did not know if Virginia required the reporting of HAI outbreaks/clusters. *In actuality, Virginia regulation requires the reporting of <u>all</u> outbreaks, including those that are healthcare-associated.*

◊ Nearly one-fifth of IPs did not feel they had a specific HAI contact person at the LHD, and almost half (44%) did not feel they had a specific HAI contact person at the SHD. *We hope that by now, more IPs are aware of the HAI Program staff at the SHD (Andrea Alvarez and Carol Jamerson) as well as their district epidemiologist and/or communicable disease nurse at the LHD.*

◊ Less than half of respondents reported that the hospital had ever received epidemiological assistance from the LHD or SHD during an HAI outbreak investigation. *Both the LHD and SHD have trained professionals to assist you epidemiologically during an outbreak investigation. Please contact the HD as soon as you have identified an outbreak and make sure they know what support you need.*

<u>Successes</u>

◊ Nearly all respondents were familiar with the process for contacting the LHD/SHD when an outbreak is suspected/detected. Out of the 31% of respondents that had an outbreak in the past two years, 100% reported it to the LHD. *Thank you!*

◊ Over half of VA respondents viewed an increased level of involvement from the SHD since January 2010. Another fourth reported the SHD had the same level of involvement since they were already so involved in HAI-related activities.

◊ Nearly three-fourths of IPs viewed the SHD as providing or being involved in training programs for HAIs. *That is great to hear, as we have been working hard to create educational opportunities for IPs.*

The survey also provided for IPs to share their thoughts on the factors that were most important in establishing an effective relationship between hospitals and the LHD/SHD. The three most important factors identified were:

1) Communication and interaction
2) Collaborative environment
3) Health department availability

Some suggestions on how to establish this effective relationship were to get to know all parties involved and meet *before* a problem arises. Knowledge of each other's job functions can also be helpful. Face-to-face meetings, such as regional IP meetings, were viewed as successful ways to build relationships and establish open lines of communication.

If you are interested in more Virginia-specific results, please contact Andrea Alvarez (andrea.alvarez@vdh.virginia.gov).

Article citation: Stricof RL, Hanchett M, Beaumont J, Kaiser K, Graham D. The relationship of public health to the infection preventionists in United States hospitals, 2011: A partnership for change. *Am J Infect Control*. 2012;40: 392-395. **www.ajicjournal.org**

<u>Open for Public Comment</u>: Long-Term Care Chapter of the Department of Health and Human Services National Action Plan to Prevent HAIs. Submit comments to **OHQ@hhs.gov** by *5 PM on August 22nd*. To read the draft chapter, go to: **www.hhs.gov/ash/initiatives/hai/actionplan/ltc_facilities508.pdf**

Unsafe Injection Practices in the News

In the past few issues of this newsletter, we have highlighted toolkits, guidelines, and resources to address safe injection practices. This month, we have more information to share, as several large multistate investigations underscore the fact that injection safety is a major public health issue that continues to affect facilities across the continuum of care and necessitates enhanced education and coordination between local and state jurisdictions.

COLORADO: Over a 12 year period ending in 2011, an oral surgeon in the Denver area reused needles and syringes in two clinics. Thousands of past patients, who now live in >35 states, are now being notified about the potential for transmission of bloodborne pathogens and are encouraged to be tested for hepatitis B, hepatitis C, and HIV if they received IV medications during the exposure period. No cases of disease transmission have been identified yet.

NEW HAMPSHIRE: A hospital healthcare worker has been accused of stealing pain medication from a cardiac catheterization lab, injecting himself, and contaminating syringes that were later used on patients. Thirty cases of hepatitis C have been documented thus far among patients receiving care in this hospital. As in the Colorado situation, thousands of past patients have been notified about their potential for exposure and are in the process of being tested.

Publications and Guidance:

The July 13th edition of *MMWR* highlighted two outbreaks that involved transmission of invasive *Staphylococcus aureus* associated with reuse of single-dose vials of pain medication in outpatient clinics. In Arizona, three cases of methicillin-resistant *S. aureus* (MRSA) resulted from reuse of single-dose vials of pain medication at a pain management clinic. In Delaware, 7 cases of methicillin-susceptible *S. aureus* were identified among patients in an orthopedic clinic who all received doses of pain medication from single-dose vials that were shared among multiple patients. To access the article, go to: **www.cdc.gov/mmwr/PDF/wk/mm6127.pdf**

Dovetailing CDC's reissuance of its position on the use of single-dose/single-use vials (see May's newsletter or **www.cdc.gov/injectionsafety/CDCposition-SingleUseVial.html**), on June 15th, the Centers for Medicare and Medicaid Services (CMS) issued a memorandum clarifying its guidance regarding the conditions under which it is permissible to repackage of single-dose or single-use vials into smaller doses, each intended for a single patient. When previously unopened single-dose vials are repackaged consistent with aseptic conditions under the requirements of USP <797> (United States Pharmacopeia General Chapter 797, *Pharmaceutical Compounding—Sterile Preparations*) and subsequently stored consistent with USP <797> and the manufacturer's package insert, it is permissible for healthcare personnel to administer repackaged doses derived from single-dose vials to multiple patients, provided that each repackaged dose is used for a single patient in accordance with applicable storage and handling requirements (**www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Downloads/Survey-and-Cert-Letter-12-35.pdf**).

Field Epidemiology Seminar Recap

On June 27, VDH held its annual Field Epidemiology Seminar in Richmond, sharing lessons from case investigations and outbreaks of the past year. It was wonderful to see so many infection preventionists in the audience! Three of the presentations described healthcare-associated outbreak investigations.

Barbara Stein, IP Director from Children's Hospital of the King's Daughters, did an excellent job sharing the story of an outbreak of *Salmonella* that occurred in the neonatal intensive care unit (NICU) and was associated with reptile exposure. Jessica Watson, district epidemiologist from Henrico, described an outbreak of *Acinetobacter baumannii,* also in a NICU. Lack of terminal cleaning of key pieces of ventilator equipment may have facilitated the spread of infection in that outbreak. Lastly, Kate Corvese, CDC/CSTE Applied Epi Fellow, presented about an outbreak of invasive Group A *Streptococcus* among residents of a long-term care facility.

Updated CDC Recommendations for the Management of Hepatitis B Virus-Infected Healthcare Providers and Students

On July 6th, CDC published updated recommendations for the management of hepatitis B virus (HBV)-infected healthcare providers and students. This document reflects changes in the epidemiology of HBV infection in the United States, advances in the medical management of chronic HBV infection, as well as policy directives that have been issued by health authorities since recommendations were last published in 1991. The report emphasizes prevention of healthcare provider injuries and blood exposures during exposure-prone surgical, obstetrical, and dental procedures.

These updated recommendations reaffirm the 1991 CDC recommendation that HBV infection alone should not disqualify infected persons from the practice or study of surgery, dentistry, medicine, or allied health fields.

The previous recommendations have been updated to include the following changes:

- ◊ no prenotification of patients of a healthcare provider's or student's HBV status required
- ◊ use of HBV DNA serum levels rather than hepatitis B e-antigen status to monitor infectivity
- ◊ for those healthcare professionals requiring oversight (as defined in the report), specific suggestions for composition of expert review panels and threshold value of serum HBV DNA considered "safe" for practice (<1,000 IU/ml).

These recommendations also explicitly address the issue of medical and dental students who are discovered to have chronic HBV infection. For most chronically HBV-infected providers and students who conform to current standards for infection prevention, HBV infection status alone does not require any curtailing of their practices or supervised learning experiences. These updated recommendations outline the criteria for safe clinical practice of HBV-infected providers and students that can be used by the appropriate occupational or student health authorities to develop their own institutional policies.

To read the report in its entirety, go to:
www.cdc.gov/mmwr/pdf/rr/rr6103.pdf

NHSN Notes

NHSN Q&A

Q. There has been concern that the method of testing for *Clostridium difficile* infection (CDI) will affect what is being measured by NHSN. Many hospitals are changing their method to PCR testing, which drastically increases the number of CDI cases. The MDRO/CDAD module does not currently collect lab testing method. Are there any efforts underway to address this issue?

A. NHSN response: Information on CDI testing method is collected on the facility survey each year. We are in the middle of performing the risk adjustment for CDI LabID event and are definitely including PCR testing as a potential factor in the risk adjustment.

Q. A patient was discharged from my facility and was readmitted to another hospital, where a surgical site infection was identified and attributed to my hospital. I'm entering the SSI into NHSN, but the system won't let me save it. Help!

A. NHSN will not let you save when the event date is after the discharge date. In a situation like this, in the "Identified" field, you need to select "RO". This option means that the patient was discharged from your facility, admitted to another, and then the infection was identified. With this selected, you should have no problem saving the SSI event.

Other NHSN Reminders

Don't forget to get your 2012Q1 data into NHSN by **AUGUST 15th** to be in compliance with CMS reporting requirements. For CLABSI and CAUTI, make sure summary data are entered for each location for each month and check the "Report No Events" box on the summary data form if no infections were identified.

For SSI reporting, make sure colon and abdominal hysterectomies are in your monthly reporting plans for each month. Check the "No Procedures Performed" (see NHSN Alerts—Missing Procedures) or "Report No Events" (see NHSN Alerts—Missing PA Events) as appropriate.