SYNERGY: COMBINING EFFORTS FOR HAI PREVENTION

September 2012

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

Volume 3, Issue 9

Edited by: Andrea Alvarez

Notes from VDH

Infection Prevention Week is almost here! How is your facility planning to celebrate October 14-20? Check out APIC's website for some ideas: **http://iipw.site.apic.org**. If your facility organizes any educational initiatives or special activities to engage patients or healthcare providers, let us know! We'll share your stories in next month's newsletter.

Recent updates to our website:

◊ Added a one-page flyer for patients and family members on tips for preventing infection following surgery. This was adapted from a discharge education tool used by Centra Health and published in APIC's Summer 2012 issue of *Preventing Infection in Ambulatory Care*. Thanks, Centra! **www.vdh.virginia.gov/epidemiology/surveillance/hai/ssi.htm**

◊ Added an in-service on basic infection prevention principles (*Infection Prevention and Control: Prevention Strategies*) that is applicable for ambulatory care (outpatient) settings. **www.vdh.virginia.gov/epidemiology/surveillance/hai/ambulatory.htm**

APIC-VA Educational Conference Recap

The 38th annual education conference of the Virginia chapter for the Association for Professionals in Infection Control and Epidemiology (APIC-VA) was held September 20-21, 2012 in Fairfax and was attended by infection preventionists (IPs), public health professionals, and healthcare quality partners from around the state.

A pre-conference workshop on September 19th targeted construction in healthcare and emergency preparedness. The two-day APIC-VA conference was filled with enthusiastic and expert speakers addressing infection prevention topics across the continuum of healthcare. APIC's Chief Executive Officer, Katrina Crist, opened the conference speaking to APIC's mission to *create a safer world through prevention of infection*. Karen Hoffmann from CMS (Centers for Medicare and Medicaid Services) discussed a new tool used by hospital surveyors to assess compliance with the Medicare Conditions of Participation for Infection Control.

Other conference highlights included presentations from leaders in infectious diseases addressing the critical issues with the identification and prevention of multidrug-resistant organisms including carbapenem-resistant *Enterobacteriaceae*. Evidence-based approaches to management of sepsis and other clinical syndromes were shared with the attendees. *Clostridium difficile* infection risk factors, prevention challenges, and treatment options were discussed.

The VDH HAI Program led a roundtable discussion of disease updates and tools for infection prevention in long-term care settings, which provided opportunities to share recently published surveillance definitions and disease outbreak "lessons learned". Rounding out the conference agenda was a session containing interactive case studies where attendees applied National Healthcare Safety Network definitions to scenarios. For information on membership in APIC-VA, please visit their website: **www.apic-va.com.**

In this issue:

Upcoming Events:

Oct 2-4 (8 AM-5 PM each day): CDC NHSN training (live webcast) (see pg 4)

Oct 3, Oct 11: CDC webinar on Healthcare Personnel Flu Vaccination Module (see pg 3)

Oct 24, 2 PM: VDH/VHQC *C. diff* Infection Prevention Collaborative Webinar

Contact:

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

Spotlight on Surveillance in Long-Term Care

In September, two resources were released that impact long-term care facilities' capacity to conduct infection surveillance. The first is the publication of revised surveillance definitions (*Infection Control and Hospital Epidemiology* Oct 2012). An expert consensus panel revisited the infection surveillance definitions for long-term care facilities published by McGeer et al. in 1991. The revised definitions reflect changes to the body of evidence-based literature about infections in the elderly in the long-term care setting, the availability of improved diagnostics for infection surveillance, the changing populations of patients who are cared for in nonhospital settings, and the updated acute care hospital surveillance definitions of the CDC's National Healthcare Safety Network (NHSN). Significant changes were made to the criteria defining urinary tract infections and respiratory tract infections. Minor changes were made to constitutional criteria, including fever, acute change in mental status, and acute functional decline. New definitions were added for norovirus gastroenteritis and *Clostridium difficile* infections. To access the article, go to: **www.jstor.org/stable/10.1086/667743**

The second resource impacting LTC infection surveillance is the release of the NHSN Long-Term Care Facility Component, which provides participating facilities with standardized protocols and reporting mechanisms. This part of the NHSN system is designed for use by nursing homes, skilled nursing facilities, chronic care facilities, and assisted living and residential care facilities. It contains modules to report urinary tract infections, *C. difficile*, methicillin-resistant *Staphylococcus aureus* and other drug-resistant infections, and prevention process measures including hand hygiene adherence. Additional information about enrolling and reporting into the LTCF Component (including forms, protocols, and trainings) can be found on the NHSN website: **www.cdc.gov/nhsn/LTC/index.html**.

NHSN News

The latest version of NHSN (7.0) was released on September 14th. In addition to the *new* Long-Term Care Component and the revised Vaccination Module of the Healthcare Personnel Safety Component already described in the newsletter, there are a few notable changes/additions:

◊ The home page of each Component includes an "Action Items" table. This contains all of the notifications that NHSN delivers to users in a single place, including alerts to report no events or no procedures, and updated confer rights templates for groups.

◊ The NHSN alerts tabs have been updated. Users can now sort and display all alerts for a given tab. Additional "Report No Events" boxes and links to create missing summary records have been added to the alerts tabs.

◊ Critical access hospitals can now update their facility type in NHSN. To do this, click on "Facility" and then "Facility Info" on the NHSN navigation toolbar. In the "Facility Type" dropdown menu, change the hospital type to "HOSP-CAH" and click the "Save" button.

◊ Each of the reports that preview the facility-specific data that will be sent to CMS has been placed into a single folder. After clicking "Analysis" and "Output Options" on the NHSN navigation toolbar, click "Advanced" —> "CMS Reports" —> "CDC Defined Output" to view these reports.

◊ A new analysis output option allows the user to view complex 30 day surgical site infection (SSI) standardized infection ratio (SIR) data by surgeon. The report can be found by clicking "Analysis"—> "Procedure-Level Data" —> "CDC Defined Output"—> "SIR-Complex 30 Day SSI Data by Surgeon"

◊ NHSN can now receive the following data via Clinical Document Architecture (CDA)

- Dialysis Event numerator form
- Dialysis Event denominator form
- MDRO/CDI Module denominator form

For more information on NHSN v7.0, please read the NHSN v7.0 (September 2012) Release Notes that were e-mailed to NHSN users on September 17th.

Healthcare Personnel Influenza Vaccination Reporting Requirements: What Does it Mean for My Facility?

Acute care hospitals participating in the Centers for Medicare and Medicaid Services (CMS) Hospital Inpatient Quality Reporting Program are required to report healthcare personnel influenza vaccination data through the National Healthcare Safety Network (NHSN) beginning January 1, 2013. In August, CMS passed a Final Rule that will require long-term acute care hospitals to report these data as well, beginning in October 2013.

The NHSN Healthcare Personnel Safety Component is the platform that will be used to collect the data. Although this component has been in existence for a few years, the Vaccination Module has recently been edited and updated with new protocols and forms to facilitate the reporting of HCP influenza vaccination data on the *summary* level. This means that data are reported on the facility level, not the individual level and will reflect vaccinations for employees, licensed independent practitioners, and adult students/trainees and volunteers. For the 2012-2013 influenza season, acute care hospitals can submit data for the entire flu vaccination season to NHSN and CMS will accept *voluntarily* submitted data for vaccinations given prior to January 1, 2013, but submission of these data is *not required* by the CMS rule. For the subsequent flu season, acute care and long-term acute care hospitals will report vaccinations for the entire season (October 1, 2013—March 31, 2014).

Several educational resources are available to help facilities become familiar with the protocol, data entry screens, and analysis functions to prepare for reporting.

- VDH HAI Program webinar recording and slides (9/26): **www.vdh.virginia.gov/epidemiology/surveillance/hai/communication.htm**
- CDC webinars offered 10/3 (12-1 PM) or 10/11 (2-3 PM) are now full. Check **www2.cdc.gov/vaccines/ed/nhsn** for future webinars and archives of past offerings.
- NHSN Vaccination Module website, including protocol, forms, and operational guidance for CMS reporting: **www.cdc.gov/nhsn/hps_vacc.html**

The Use of Live Attenuated Influenza Vaccine (LAIV) in Healthcare Personnel (HCP): Updated Guidance from the Society for Healthcare Epidemiology of America (SHEA)

Live attenuated influenza vaccine (LAIV) is licensed for healthy, nonpregnant persons aged 2-49 years and provides adults with another option for influenza vaccination, especially for those with an aversion to needles. Because the vaccine has a live viral backbone, questions have been raised regarding infection prevention precautions and restrictions surrounding the use of LAIV in healthcare personnel (HCP).

In the October 2012 issue of *Infection Control and Hospital Epidemiology*, the Society for Healthcare Epidemiology of America (SHEA) Task Force on Healthcare Personnel Influenza Vaccination issues guidance regarding the use of LAIV in this population and the infection prevention precautions that are recommended with its use.

The quantity of attenuated virus that is shed in the first few days following vaccination with LAIV is 100-10,000-fold lower than the median human infectious dose required for LAIV vaccination in adults. Studies have noted the safety of administering LAIV to some populations of immunocompromised patients of concern, including HIV-positive children and adults, children with cancer, and older adults with chronic obstructive pulmonary disease. Prior recommendations by the Advisory Committee on Immunization Practices and the Healthcare Infection Control Practices Advisory Committee stated that LAIV should not be administered to HCP who interact with patients who at the time of contact require a "protective environment" such as in myelosuppression or stem cell transplantation units, and were made in an abundance of caution to err on the side of patient safety.

SHEA endorses the use of LAIV in the HCP population as an alternative to the inactivated influenza vaccine, especially for those who are fearful of needles. SHEA agrees with the restriction of LAIV from HCP who, in the week following vaccination, have *frequent* contact with patients who reside in a protective environment. All other HCP, including those who have the potential for *infrequent* contact with patients in protective environments, or who provide care to other immunosuppressed populations (e.g., neonatal or burn unit patients) *should not be excluded* from vaccination with LAIV.

To access the entire article, go to: **www.jstor.org/stable/10.1086/667772**

Infectious Diseases Society of America (IDSA) Clinical Practice Guidelines on Group A Streptococcal Pharyngitis

In early September, the Infectious Diseases Society of America (IDSA) published a clinical practice guideline for the diagnosis and management of group A streptococcal pharyngitis that updated a guideline issued by IDSA in 2002. The publication, in the September issue of *Clinical Infectious Diseases*, is intended for use by healthcare providers who care for adult and pediatric patients with group A streptococcal pharyngitis.

Swabbing the throat and testing for group A streptococcal pharyngitis by rapid antigen detection test and/or culture should be performed because the clinical features alone do not reliably distinguish between group A strep and viral pharyngitis. In children and adolescents, it is recommended that negative rapid tests be backed up by a throat culture. Positive rapid tests do not need a back-up culture because they are highly specific. Testing for group A strep pharyngitis is not recommended for children or adults with clinical and epidemiological features that suggest a viral etiology, such as cough, rhinorrhea, hoarseness, and oral ulcers. Penicillin and amoxicillin remain the treatments of choice and recommendations are made for the penicillin-allergic patient, which now include clindamycin. Adjunctive therapy may be useful to manage symptoms; acetaminophen or an nonsteroidal anti-inflammatory drug (NSAID) may be used to treat moderate to severe symptoms or control high fever, but use of a corticosteroid is not recommended. Aspirin should be avoided in children.

To view the complete recommendations, go to: **www.idsociety.org/uploadedFiles/IDSA/Guidelines-Patient_Care/PDF_Library/2012%20Strep%20Guideline.pdf**

Training Opportunities and Educational Resources

Several infection prevention training opportunities and educational resources are available:

Online resources:

1) "Protocol, Analysis, and Reporting: Getting the Most from NHSN" - October 2-4, 8 AM—5 PM. Free. Access via one of two weblinks: **http://wm.onlinevideoservice.com/CDC1** or **http://wm.onlinevideoservice.com/CDC2** (for slower connections)
2) Audit tools, protocols, and checklists used by the CDC Dialysis Bloodstream Infection Prevention Collaborative (**www.cdc.gov/dialysis/collaborative/tool-resources/index.html**)
3) CDC Expert Commentary on preventing infections during chemotherapy (**www.medscape.com/viewarticle/769195**). Short Medscape video that references materials and resources on CDC's website (**www.cdc.gov/cancer/preventinfections/index.htm**)

In-person trainings:

1) Infection Prevention in Emergency Departments (EDs)

One-day conference for emergency physicians and nurses, IPs, and quality and patient safety administrators to identify key issues in infection prevention for EDs, review best practice case studies, and develop a research agenda. **October 7th**. Hyatt Regency Denver at Colorado Convention Center. Registration is *free* and breakfast and lunch are included. To learn more or express interest in attending, go to: **www.acep.org/saContent.aspx?id=86921** and email **edhaiconf@partners.org**. Sponsored by the Agency for Healthcare Research and Quality, American College of Emergency Physicians, & APIC.

2) Infection Control Part II: The Infection Preventionist as an Environmentalist

This course is for hospital infection preventionists to broaden their knowledge on infection control topics including sterilization, disinfection, antibiotic utilization, infections in high-risk groups, and epidemic situations. **October 29th-November 2nd**. Chapel Hill, NC. Registration is $620 for out-of-state residents. To register and view the draft agenda, go to: **fridaycenter.unc.edu/pdep/icii/index.htm**. Sponsored by NC-SPICE.

Clostridium difficile Infection Prevention Collaborative: Get Involved!

Let's do things *diff*erently!

You've tried everything you can and *Clostridium difficile* (*C. diff*) is still one of the toughest healthcare-associated infections (HAIs) in your facility. It's time to band together to defeat *C. diff* on every front, in multiple settings of care and in the community. As healthcare providers and infection preventionists, we must act quickly to stop the spread of *C. diff* and make a *diff*erence for our patients.

Join VHQC and the Virginia Department of Health (VDH) by actively participating in a one-year improvement collaborative to significantly reduce rates of *C. diff* in hospitals and nursing homes.

Why is this project *diff*erent?

The collaborative equips providers with evidence-based *C. diff* prevention strategies that can rapidly reduce infection rates in facilities. As a project participant, you will learn from HAI prevention experts and engage with peers to discuss challenges and identify strategies for success. Online resources and conveniently scheduled calls ensure that the collaborative will not interfere with your day-to-day responsibilities. We will assist participants as they implement rapid-cycle improvement and collect and report *C. diff* rates on a quarterly basis. Data reporting not only helps your facility assess progress, but also will prepare you for mandatory reporting of *C. diff* beginning in January 2013.

How can I make a *diff*erence in my community?

The collaborative will give you access to knowledge, tools and resources needed to significantly reduce rates of *C. diff* across your facility, resulting in healthier patients and lower healthcare costs. By working together, we can:

- Decrease *C. diff* infection rates in participating facilities
- Standardize *C. diff* surveillance methods and reporting
- Raise patient and public awareness about the dangers of antibiotic resistance
- Support compliance with The Joint Commission's National Patient Safety Goals and Standards

Commit to a *diff*erent approach to patient care!

To learn more and sign up, visit www.vhqc.org or contact:

Jennifer Reece, RN, MSN, CIC, jreece@vaqio.sdps.org or 804.289.5320

Amy Lenz, BSBA, alenz@vaqio.sdps.org or 804.287.0286