

# SYNERGY: COMBINING EFFORTS FOR HAI PREVENTION

February 2014

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

Volume 5, Issue 2

Edited by:  
Andrea Alvarez

## Notes from VDH

In February 2012, the VDH Healthcare-Associated Infections Program debuted a new HAI website with resources for consumer and professional audiences across the continuum of care, including guidance for acute care, long-term care, and ambulatory care settings.

In the two years since the website's release, the number of web hits has increased steadily, from 4,000 in March 2012 to nearly 30,000 in January 2014! We hope that the information on this site continues to be helpful to you. Please let us know what we can do to improve or add to the website.  
<http://www.vdh.virginia.gov/epidemiology/surveillance/hai/>

## Recap of HAI Pre-Conference to VHHA Patient Safety Summit

On Wednesday, January 29, healthcare providers from across Virginia attended an all-day learning session to hear national and state speakers share best practices and strategies for eliminating healthcare-associated infections.

The "Working Together to Prevent Healthcare-Associated Infections" educational event featured Dr. Loria Pollack, Medical Officer with the Centers for Disease Control and Prevention's Division of Healthcare Quality Promotion, Prevention Response Branch, who took antibiotic stewardship beyond the basics, and Dr. Michael Edmond, Professor of Internal Medicine in the Division of Infectious Diseases at Virginia Commonwealth University, who talked about

We have recently found out that NHSN does not have a way to flag accounts as they transition from digital certificates to SAMS (secure access management system). In other words, if you are having access issues and send a message to the Help Desk, be sure to note if you are using a digital certificate or SAMS to access the system.

*Do you have questions about the transition from NHSN digital certificates to SAMS?* The process to convert all NHSN users to SAMS will take at least 12-18 months. In the meantime, if you have questions, your answers may be found here: <http://www.cdc.gov/nhsn/sams/sams-user-faq.html>

some of the challenges associated with HAI surveillance.

Hospital success stories involving a safety coach program and working with the local health department to improve hand hygiene gave participants some practical examples of ways to build and sustain improvement. Finally, a panel of Virginia physicians shared strategies for engaging physicians in change to improve quality and patient safety. This session was jointly sponsored by the Virginia Hospital & Healthcare Association (VHHA), the North Carolina/Virginia Hospital Engagement Network (NoCVA HEN) and the state quality improvement organization, VHQC.

### In this issue:

Notes from VDH	<b>1</b>
Recap of HAI Pre-Conference to VHHA Patient Safety Summit	<b>1</b>
Healthcare Personnel Attire	<b>2</b>
Infection Prevention Policies and Programs in Hospital ICUs	<b>2</b>
HHS Sponsors Development of New Antibiotic	<b>2</b>
NHSN Notes	<b>3</b>
Injection Safety Updates	<b>3</b>
Business Pulse: Safe Healthcare	<b>3</b>
CRE NDM Outbreak—Endoscopes	<b>4</b>
Well-Child Visits and Risk for ILI	<b>4</b>
Establishment of NAPSICO	<b>4</b>
VDH Preparedness Academy & Field Epi Seminar Registration	<b>5</b>

### Upcoming Events:

**April 3 (Roanoke) and April 15 (Williamsburg):** NoCVA HEN regional learning sessions on science of safety and learning from defects. Contact Ashlee McDearmon with questions ([amcdearmon@vhha.com](mailto:amcdearmon@vhha.com), 804-965-5714)

### Contact:

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

## Society for Healthcare Epidemiology of America (SHEA) Guidance on Healthcare Personnel Attire in Non-Operating Room Settings

The Society for Healthcare Epidemiology of America (SHEA) issued expert guidance on healthcare personnel (HCP) attire in non-operating room settings in the February 2014 issue of *Infection Control and Hospital Epidemiology*. This paper consisted of three elements intended to establish best practices on HCP attire: (1) a review of existing literature about patient and provider expectations of provider attire and the potential risk for microorganism transmission; (2) an evaluation of existing hospital policies as submitted to the SHEA Guidelines Committee; and (3) a survey of SHEA members that examined hospital policies and HCP perceptions of HCP attire in the cross-contamination of pathogens. The literature review was inconclusive regarding both patient and provider perceptions of HCP attire, with patient perceptions varying based on the age of both patient and

physician, gender of the physician, time of day, care setting, and the attire patients were accustomed to seeing. Hospital policies on attire varied greatly in that most had policies regarding general appearance but few addressed specific attire requirements. The survey of SHEA members found that the enforcement of HCP attire policies was very low and a majority of respondents felt that attire played an important role in the transmission of pathogens.

Recommendations on the use of white coats, neckties, footwear, the “bare-below-the-elbows” strategy, and laundering were provided in this guidance document. The main conclusion was that additional study is needed to establish evidence-based practices for HCP attire. To view the SHEA expert guidance, go to: <http://www.jstor.org/stable/10.1086/675066>.

## Infection Prevention Policies and Programs in Hospital Intensive Care Units

The February issue of *American Journal of Infection Control* featured an article sharing results from a mixed-methods study of 1,534 intensive care units (ICUs) in 975 hospitals and their infection prevention policies and processes. The authors concluded that acute care hospitals need updated guidelines for infection prevention staffing and certification, and hospitals need to be held accountable for compliance with published guidelines. The report analyzed hospital policies regarding central line-associated bloodstream infection (CLABSIs), ventilator-associated pneumonia (VAP), and catheter-associated urinary tract infection (CAUTI) prevention. In addition, the study examined the characteristics of infection prevention and control programs, including detailed staffing information, use of electronic monitoring systems, and the hours of data

management and secretarial support per week. CLABSI policies were the most widespread, followed by VAP, and CAUTI prevention was addressed in less than two-thirds of hospitals. More than one-third of responding hospitals did not have a certified infection preventionist (IP); presence of a certified IP is a significant predictor of lower multidrug-resistant organism HAI rates. Another finding of concern was the lack of a hospital epidemiologist in almost 50% of responding facilities. Although the study’s response rate was low (29% of the eligible hospitals), the findings provide a comprehensive national snapshot of infection prevention programs in intensive care units in the United States.

To view the full text of the article, go to: [http://www.ajicjournal.org/article/S0196-6553\(13\)01310-2/fulltext](http://www.ajicjournal.org/article/S0196-6553(13)01310-2/fulltext)

## HHS Sponsors Development of New Antibiotic

The United States Department of Health and Human Services has partnered with Rempex Pharmaceuticals Inc. to develop Carbavance, a new drug that shows promise to treat antibiotic-resistant infections, including carbapenem-resistant Enterobacteriaceae (CRE). In addition to treating CRE, Carbavance could be used

commercially to treat other types of infections including complicated urinary tract infections, hospital-acquired pneumonia, and ventilator-associated pneumonia. HHS has pledged funding support for five years under this public-private partnership.



## National Healthcare Safety Network (NHSN) Notes

ICD-9 Mapping Guidance for HPRO - Hip Arthroplasty and KPRO - Knee Arthroplasty: The NHSN Denominator for Procedure form will collect additional detailed information about 2014 HPRO and KPRO procedures. However, there is a defect in the NHSN application that will trigger an error message with the mapping tool originally provided. Be sure to use the updated guidance (2/3/14) to address this issue: <http://www.cdc.gov/nhsn/PDFs/ICD-9-Mapping-tool-HPRO-KPRO.pdf>.

SSI: Changes have been made to reporting of SSIs and procedure denominators to NHSN in 2014, including the addition of a new “periprosthetic joint infection” SSI definition and the addition of new fields on the denominator form. A summary of the reporting changes is posted at <http://www.cdc.gov/nhsn/commUp.html>.

VAE: VAE reporting has transitioned from age-based surveillance to location-based surveillance. Surveillance is restricted to adult inpatient locations only, and is not performed in pediatric, mixed age, or neonatal locations. Additional information can be found in the VAE protocol and in the summary of 2014 NHSN surveillance changes posted at <http://www.cdc.gov/nhsn/commUp.html>.

New Optional Question for BSI: An optional question about the presence of a hemodialysis catheter has been added to the bloodstream infection form. If used consistently, this field can identify the proportion of inpatient central line-associated bloodstream infections (CLABSIs) occurring among hemodialysis patients, and could prompt additional or more targeted CLABSI prevention efforts. 2013 data can be entered retrospectively.

## Injection Safety Updates

- The Food and Drug Administration (FDA) issued a warning in early February about calcium gluconate injections that tested positive for gram negative rod bacteria: <http://www.fda.gov/Safety/MedWatch/SafetyInformation/SafetyAlertsforHumanMedicalProducts/ucm385125.htm>.
  - ◇ Clinicians should follow up with patients who were given calcium gluconate 10% injections that were manufactured by Rx Formulations between 11/7/13 and 12/11/13 (lot #778961).
  - ◇ Healthcare providers should check their medical supplies and quarantine the affected products.
  - ◇ Any adverse events or side effects related to the use of these products should be reported to the FDA’s MedWatch Safety Information and Adverse Event Reporting Program ([www.fda.gov/medwatch/report.htm](http://www.fda.gov/medwatch/report.htm)).
- *Safe In Common* is a nonprofit organization of healthcare professionals and advocates that strives to raise awareness and save lives of workers at risk for needlestick injuries. To access their resources pertaining to safe injection practices, please go to their website: [www.safeincommon.org](http://www.safeincommon.org)

## CDC Foundation Business Pulse: Safe Healthcare

The CDC Foundation is an independent, nonprofit organization that connects the Centers for Disease Control and Prevention (CDC) with private-sector organizations and individuals to build public health programs that make our world healthier and safer.

Each quarter, the CDC Foundation releases “Business Pulse”, a feature that offers businesses useful resources from the CDC on a topic of relevance to businesses and their workforces.

The Business Pulse topic for the first quarter of 2014 is safe healthcare and discusses the growing problems of healthcare-associated infections and antibiotic resistance. An infographic educates businesses about the ways in which initiatives and resources from the CDC help safeguard businesses and the workforce from infections and lower healthcare costs. To view the Business Pulse Infographic: <http://www.cdcfoundation.org/businesspulse/safe-healthcare-infographic>

To access the entire Business Pulse, go to:

<http://www.cdcfoundation.org/businesspulse>

## Outbreak of NDM-Producing Carbapenem-Resistant Enterobacteriaceae Associated with Endoscopes

Between March and July 2013, nine patients in northeastern Illinois cultured positive for New Delhi metallo- $\beta$ -lactamase (NDM)-producing *E. coli*. After a thorough investigation into these patients, it was discovered that almost all had undergone an endoscopic retrograde cholangiopancreatography (ERCP) procedure at one hospital. Subsequent testing of the ERCP endoscopes cultured NDM-producing *E. coli* and *Klebsiella pneumoniae* carbapenemase (KPC)-producing *K. pneumoniae*, even after the endoscopes underwent the recommended manual cleaning and high-level disinfection procedures. An additional 23 cases with NDM-producing

*E. coli* were identified among patients with previous ERCP procedures. The hospital switched to gas sterilization for their ERCP endoscopes and no further cases have been identified. This outbreak emphasizes the role endoscopes can play in CRE transmission and has raised several questions about the challenges involved with reprocessing complex endoscopes like those used in ERCP procedures.

For more information, please read the following article in the January 3, 2014 issue of *MMWR*:

[http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6251a4.htm?s\\_cid=mm6251a4\\_w](http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6251a4.htm?s_cid=mm6251a4_w).

## Well-Child Visits and Risk for Contracting Influenza-Like Illness

Jacob Simmering and colleagues published an article in the March 2014 issue of *Infection Control and Hospital Epidemiology* examining whether well-child visits are a risk factor for subsequent influenza-like illness (ILI) visits. After analyzing 13 years of data from the Medical Expenditure Panel Survey, the authors concluded that “an ILI office visit by a family member was positively associated with a well-child visit in the same or one of the previous two weeks”, with an odds ratio of 1.54. Put in different terms, this equates to nearly 779,000 excess cases of ILI per year, with a cost of \$500 million annually.



Current infection prevention guidelines emphasize the importance of hand hygiene as well as respiratory hygiene and cough etiquette, especially during cold and flu season. This article’s findings stress the need to improve compliance with current infection prevention guidelines in the ambulatory setting. In addition, the authors suggest that clinics could consider shifting the scheduling of well-child visits to not coincide with the peak of flu season.

To access the article: <http://www.jstor.org/stable/10.1086/675281>

This issue also features a commentary by Lisa Saiman that discusses the implications of these findings: [www.jstor.org/stable/10.1086/675349](http://www.jstor.org/stable/10.1086/675349)

## Establishment of National Association of Public Safety Infection Control Officers

The National Association of Public Safety Infection Control Officers (NAPSICO) is launching on March 1, 2014. This organization is a non-profit association established to provide Designated Infection Control Officers (DICOs) the tools needed to develop and manage effective infection control programs.

Federal law (Part G of the Ryan White HIV/AIDS Treatment Extension Act of 2009) requires that every emergency response agency have a DICO to serve as a liaison between emergency responders and medical facilities to manage emergency response employees’ occupational exposure to infectious disease. Virginia

regulations require the DICO be formally trained for this position and knowledgeable in proper post-exposure medical follow-up procedures and current regulations and laws governing disease transmission.

NAPSICO is focused directly on the educational needs of the public safety sector DICOs. All information provided will be evidence-based, covering diseases and infection control. NAPSICO will provide related legal compliance information to round out a complete program. After March 1st, visit the website at [www.NAPSICO.org](http://www.NAPSICO.org) to see what is offered.

For more information on NAPSICO, please contact Katherine West at 703-365-8388 or [info@ic-ec.com](mailto:info@ic-ec.com).

# Public Health and Healthcare Preparedness Academy May 20-21, 2014

## Strengthening Our Capabilities to Meet the Challenges of Tomorrow

Join public health, healthcare, and emergency management professionals for cross-disciplinary learning opportunities.

Topics include: Lessons Learned from the West Virginia Chemical Spill, Using Social Media Effectively in Disasters, Allocation of Scarce Resources, Impact of Medical Records Exchange on Preparedness, and many more!

You will also hear best practice presentations from your public health and healthcare partners from across the Commonwealth!

### Register to attend

Registration is now available on TRAIN Virginia.

- Go to <https://va.train.org>
- Search for course ID 1049482

Please note that you must register separately for the post conference meetings.

## Post Conference Meetings on May 22, 2014

### VDH Field Epidemiology Seminar

Register now

- Go to <https://va.train.org>
- Search for course ID 1049498

### Incident Management Training

Register now

- Go to <https://va.train.org>
- Search for course ID 1049499

## Need more information?

Visit [www.virginiapreparednessacademy.blogspot.com](http://www.virginiapreparednessacademy.blogspot.com) for the latest information, including the agenda and travel information.



An Alliance of hospitals and health delivery systems

