

SYNERGY: COMBINING EFFORTS FOR HAI PREVENTION

August 2015

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

Volume 6, Issue 8

Edited by:
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Notes from VDH

This month, we welcomed two more members of the VDH HAI team. **Mefruz Haque, MPH** is a Centers for Disease Control and Prevention (CDC)/Council of State and Territorial Epidemiologists (CSTE) Applied Epidemiology Fellow assigned to the Virginia Department of Health for the next two years.

Emily (**Em**) **Stephens** will be working part-time with the HAI program, providing support as the Assistant HAI Program Coordinator, including managing a project to create an inventory of healthcare facilities in the state.

CDC Vital Signs Report: Stop Spread of Antibiotic Resistance

On August 4, the CDC released a special report regarding antibiotic resistance, as a part of its "Vital Signs" series. With an increasing number of infections caused by multidrug-resistant organisms (MDROs) (such as carbapenem-resistant Enterobacteriaceae) and *Clostridium difficile*, it is crucial that healthcare facilities implement effective antibiotic stewardship programs and infection prevention and control measures. However, as CDC notes, single-facility intervention mechanisms are not sufficient to curb resistance—coordination and communication *between* healthcare facilities is key.

Patients often transfer between healthcare facilities such as hospitals, long-term acute care facilities, and nursing homes. In order to protect patients and reduce the spread of infection, facilities must coordinate their efforts by sharing information, connecting with public health departments, and achieving leadership commitment for HAI and resistance prevention. Enhanced coordination and communication could allow for improvements in the preparation, treatment, and control of MDRO infections.

Public health officials also play a major role in facilitating interaction and communication between healthcare providers. According to the CDC, state and local health departments can identify healthcare facilities in the area, learn how each facility handles infection prevention and antibiotic stewardship, and dedicate staff whose main responsibility is to improve connections between healthcare facilities. Public health officials can also contribute to the effort by working with the CDC to access data and identifying potential MDRO threats in the area and state.

To access the report, visit: <http://www.cdc.gov/vitalsigns/stop-spread/index.html>

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Upcoming Events:

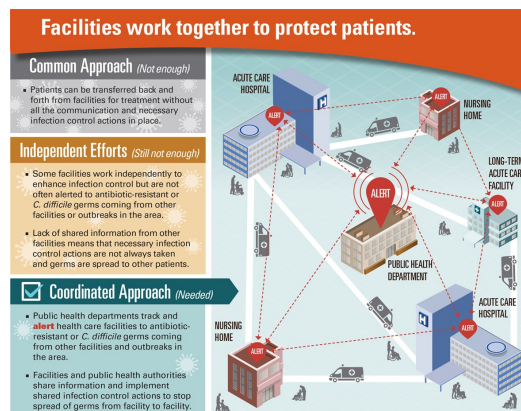
September 10, 12-1 PM: Conference call about changes to state HAI reporting regulations

September 18: Long-term care training, Carilion New River Valley Medical Center

October 15-16: APIC-VA Annual Educational Pre-Conference and Conference, Richmond, VA

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State HAI Regulatory Changes

Several years ago, VDH began the process of revising the healthcare-associated infection portion of the disease reporting regulations to expand HAI reporting.

The new reporting regulations will **align reporting to the state health department with what hospitals are already reporting to the National Healthcare Safety Network (NHSN) for the purposes of complying with the Centers for Medicare and Medicaid Services (CMS) Hospital Inpatient Quality Reporting Program.**

That way, there is no additional reporting burden on the infection preventionists; hospitals will share the data through NHSN with the health department via the confer rights function, as you already do for central line-associated bloodstream infections in adult intensive care units.

NHSN Notes

The VDH HAI Program is doing some quality assurance on data reported in NHSN about facilities' bedsize and affiliation with a medical school. This information is especially important because NHSN uses these variables in their risk adjustment models. We appreciate your follow-up if we have reached out to you about this. Thank you!

NHSN sent an e-mail on August 28th noting some changes for mapping surgical procedures to the appropriate codes. ICD-10-PCS codes will replace ICD-9-CM codes on October 1, 2015 but NHSN will not have the ability to receive these codes until the January 2016

Clinical Outreach and Communication Activity (COCA) Call Summary: Antimicrobial-Resistant Infections

On August 20th, CDC hosted a Clinical Outreach and Communication Activity (COCA) webinar presenting information on antibiotic-resistant infections, particularly carbapenem-resistant Enterobacteriaceae (CRE) and *Clostridium difficile* pathogens and antimicrobial stewardship. The prevalence of these infections is on the rise, with approximately two million patients becoming ill from antibiotic-resistant infections per year. To address the growing issue, three points of improvement were highlighted during the webinar: infection control, stewardship, and surveillance.

Key takeaways from the call include: the need to implement controls based on known epidemiology; the

The new regulations will go into effect on **September 25, 2015.**

We will be hosting a conference call for infection preventionists on **September 10th from 12-1 PM** to ask questions about the regulations. Pre-registration is not required.

Conference line: 1-866-842-5579

Passcode: 804-864-8121

Supporting documents including an FAQ about the new regulations and details about the confer rights process will be shared in the near future.

To view the final regulations, please go to the Virginia Town Hall website: <http://townhall.virginia.gov//viewstage.cfm?stageid=6905&display=documents>

NHSN release. Beginning 10/1/15 until the new release in 2016, use the NHSN operative procedure code as determined by guidance located at the following website: <http://www.cdc.gov/nhsn/acute-care-hospital/ssi/index.html>

Lastly, at the end of July, NHSN released an updated version of the software (v8.4). Minor changes were made to the Patient Safety Component and other parts of the system, including updates to the Targeting Assessment for Prevention (TAP) reports. To review all the updates, go to: <http://www.cdc.gov/nhsn/pdfs/commup/release-notes-8.4.pdf>

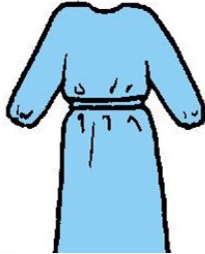
potential roles of local surveillance culture surveys and a state registry to track resistance; the understanding that duration of exposure to antibiotics is as important as being exposed itself; and the importance of reducing the use of antibiotics overall instead of substituting one agent for another. Finally, surveillance activities and interventions should not be limited to individual facilities, but should be coordinated on a regional level and beyond.

To view the slides, transcript, audio, or webcast, please visit: http://www.bt.cdc.gov/coca/calls/2015/callinfo_082015.asp

Are Healthcare Workers Appropriately Removing Personal Protective Equipment?

In a study recently published in the *American Journal of Infection Control*, researchers from the University of Wisconsin analyzed how 30 healthcare workers (HCWs) removed their personal protective equipment (PPE) after entering the room of a patient on isolation precautions. The study was conducted to determine the sequence and techniques that HCWs are using to remove PPE, and whether or not these correspond with protocols outlined by the Centers for Disease Control and Prevention (CDC).

PPE reduces healthcare-associated transmission and protects both patients and HCWs from infection. According to CDC recommendations, the correct procedure for removing PPE is to first remove contaminated gloves and then *gently* remove the gown from the back of the neck. This procedure should occur within the patient's room. Following CDC protocol is essential to reducing the spread of infection in healthcare facilities.



In this study, a trained observer stood outside of patients' rooms to observe HCWs removing PPE. HCWs were not made aware of the observer. Of the 30 HCWs observed, 13 (43%) removed PPE in the correct sequence, but only 5 (17%) correctly removed PPE *and* properly disposed of it in the patient's room.

The results of this study suggest that a majority of HCWs are not removing PPE correctly. According to the researchers, this could be because HCWs are unaware of the proper protocol or are lacking sufficient time.

To read the entire study, visit: [http://www.ajicjournal.org/article/S0196-6553\(15\)00085-1/pdf](http://www.ajicjournal.org/article/S0196-6553(15)00085-1/pdf)

To view CDC's recommendations for donning and removing PPE, visit: <http://www.cdc.gov/HAI/pdfs/ppe/ppeposter1322.pdf>

VDH resources on standard and transmission-based precautions are available here: <http://www.vdh.virginia.gov/epidemiology/surveillance/hai/StandardPrecautions.htm>

Report Finds Gaps in Evidence for Best Ways to Clean Hospital Rooms

Cleaning of hard surfaces in hospital rooms is a critical step to reduce the risk of healthcare-associated infections, but there is little evidence about what cleaning methods work best, according to a new technical brief funded by the Agency for Healthcare Research and Quality (AHRQ).

The report, *Environmental Cleaning for the Prevention of Healthcare-Associated Infections (HAIs)*, includes a review of 80 clinical studies from the last 25 years that address environmental cleaning of high-touch surfaces in hospital rooms to reduce *Clostridium difficile*, methicillin-resistant *Staphylococcus aureus* (MRSA), and vancomycin-resistant Enterococcus (VRE). The report reviewed the agents and methods used for cleaning, identified the approaches used for monitoring the effectiveness of cleaning, and determined factors needed for successful cleaning and monitoring.

While the report identified several effective cleaning tactics, there is still no definitive answer as to which practices are best to prevent HAIs. Many studies focus on counting surface contamination, such as the number of bacteria left on a surface, instead of evaluating patient outcomes (such as HAI rates). The researchers found limited studies that directly compare disinfection methods, monitoring strategies or implementation efforts. To advance research in this area, recommendations for future areas of study include: the examination and comparison of emerging strategies; the inclusion of patient colonization and infection rates as outcomes; and the identification of surfaces posing the greatest risk of pathogen transmission.

A summary of the report was published on August 10th in the *Annals of Internal Medicine*. The full report can be found at www.effectivehealthcare.ahrq.gov/healthcare-infections.

Consumer Reports Releases Hospital Ratings

Consumer Reports recently released its annual hospital safety and quality ratings in the September issue of the magazine. Since 2009, *Consumer Reports* has analyzed hospital healthcare data, ranking hospitals on a variety of measures such as readmissions and mortality. This year, however, the ratings also reflect hospitals' ability to prevent *Clostridium difficile* (*C. difficile*) and methicillin-resistant *Staphylococcus aureus* (MRSA) infections. These ratings not only allow patients to choose better care, but also alert patients to some of their hospital's weaker aspects.

To calculate each hospital's ranking, *Consumer Reports* compiled data and information from public sources, ranking hospitals based on their performance in safety, patient outcomes, patient experience, hospital practices, and heart surgery. Ratings were statistically adjusted to account for major differences in hospitals. To receive the top ranking in the prevention of *C. difficile* and MRSA infections, a hospital must report zero infections. Though seemingly challenging, 357 hospitals nationally achieved this level in *C. difficile* ratings and 322 hospitals accomplished it for MRSA.

In Virginia, the following hospitals reported zero healthcare-associated *C. difficile* infections: Bon Secours St. Francis Medical Center, Midlothian; Inova Loudoun Hospital, Leesburg; Johnston Memorial Hospital, Abingdon; Martha Jefferson Hospital, Charlottesville; Novant Health Prince William Medical Center, Manassas; and Spotsylvania Regional Medical Center,

Fredericksburg. The following Virginia hospitals reported zero healthcare-associated MRSA infections: Buchanan General Hospital, Grady; Riverside Doctors' Hospital, Williamsburg; Riverside Tappahannock Hospital, Tappahannock; and Southampton Memorial Hospital, Franklin. Congrats to these Virginia hospitals! A special congratulations goes out to Johnston Memorial Hospital in Abingdon for being one of the top nine hospitals in the nation, achieving high marks for prevention of *C. difficile*, MRSA, and three other HAIs!

Consumer Reports also notes things patients and family members can do in the hospital or at home to prevent infections, such as maintaining good hand and personal hygiene as well as questioning healthcare providers about the appropriateness of the antibiotics that are prescribed and the duration of invasive devices such as catheters and ventilators.

To view the *Consumer Reports* article, visit: <http://www.consumerreports.org/cro/magazine/2015/07/how-your-hospital-can-make-you-sick/index.htm>

To view the hospital ratings (subscription required): <http://www.consumerreports.org/health/doctors-hospitals/hospital-ratings.htm>

Class I Recall of Cook Medical Beacon Tip Angiographic Catheters

On July 2, 2015, the Food and Drug Administration (FDA) initiated a Class I recall of beacon tip angiographic catheters produced by Cook Medical. The catheters were recalled after complaints that the catheter tip may split or separate from the catheter during use. If separated, the catheter tip could enter the patient's bloodstream, causing serious injury or death to the patient. As of July 2, Cook Medical has received 26 reports of the device malfunctioning, with 14 resulting in reports of adverse events.

In a letter sent on July 2, Cook Medical asked its customers to review the list of affected products and lot numbers, collect and return all unused products to Cook Medical as soon as possible, complete the Recall Response Form attached to the letter, and report any adverse event to Cook Medical or the FDA.

To read the full recall, visit: <https://epix2.cdc.gov/v2/Reports/Display.aspx?id=50423>



41st Annual APIC VA Educational Conference
& Pre Conference Certification Review
“We’re All In This Together”
Thursday, October 15, 2015 Pre Conference
Friday, October 16, 2015 Conference
Embassy Suites, Richmond, VA

Registration for the Conference, Pre Conference, Room Reservation, Full Agenda, Map and Directions may be accessed and completed by utilizing our Regonline:

<https://www.regonline.com/apicva2015>

Agenda (abbreviated):

- 7:45 *Welcome*, Marsha Kemp
- 8:00 *Emerging Pathogens*, Dr. BaffoeBonnie
- Breakout Sessions
- 9:00 1) *New River Cross Setting-Long Term Care*, Betsy Allbee
2) *IC in the Outpatient World-Ambulatory HC*, Carolyn Kiefer
- 9:45 *MRSA Colonization & No Contact Isolation*, Janis Ober
- 10:30 Break with Vendors
- 11:00 *Research for the Novice*, Sarah Lewis
- 12:00 Lunch – Business Meeting
- 12:30 Vendors
- 2:00 *ERCP Scopes*, Dr. Bailey
- 3:00 *EBOLA*, Dr. Brigette Gleason
- 4:00 Evaluations/Wrap Up

Conference & Pre Conference Fees:

APIC Member:

Conf \$185 Pre Conf \$155, Both \$340

NonMember:

Conf \$215 Pre Conf \$205, Both \$420

Vendor: \$500

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