SYNERGY: COMBINING EFFORTS FOR HAI PREVENTION

September 2015

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

Volume 6, Issue 9

Edited by: Andrea Alvarez

Notes from VDH

This month, we had the opportunity to attend a wonderful training in the New River Valley that exemplified successful collaboration among healthcare facilities in a community. Sponsored by the New River Valley Cross-Settings Group, this educational opportunity shared infection prevention strategies for the long-term care, assisted living, and rehab settings. The training included participation from the target audiences as well as acute care facilities, the local health department, VHQC, adult daycare facilities, psychiatric facilities, and other settings. If you are interested in bringing a similar educational program to your area, please let the HAI Program know!

Updated State HAI Reporting Regulations

The new reporting regulations for the healthcare-associated infection portion of the disease reporting regulations **went into effect on 9/25/2015**. The new reporting regulations 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.

The NHSN Facility Administrator from each hospital must re-confer rights to VDH to align data sharing with the new regulations. **We are asking hospitals to complete the confer rights process in NHSN as soon as possible and no later than October 26, 2015.** We are requesting that hospitals confer rights going back to July 2008 for central-line associated bloodstream infections (CLABSI) so that we do not lose any of the data collected from 2008-2010 under the prior state reporting mandate. The VDH HAI Team is available to provide technical assistance if there are any questions about this process. Please contact Sarah Lineberger at 804-864-8135 or Sarah.Lineberger@vdh.virginia.gov.

An email with instructions about the confer rights process was sent to each hospital on Monday, September 28th. To access the confer rights template, log-on to NHSN, navigate to the left hand blue toolbar, choose Group, then Confer Rights. Hospitals will need to confer rights for both the Patient Safety Component and the Healthcare Personnel Safety Component. Please be sure to confer rights to both active and inactive units in your facility to ensure that historical data are transferred to VDH. To do so, click the dropdown box under Your Locations and select all applicable active and inactive units; check N/A if your facility does not have the specified unit(s) or perform the specified surgical procedure(s).

Critical access hospitals that voluntarily participate in the CMS Hospital Inpatient Quality Reporting Program or children's hospitals that report to NHSN are invited to join our group (group ID: 12813, password: health) and voluntarily confer rights to data for the specified HAI events and locations, as applicable in the facility. Sharing your data will allow VDH to have a more complete picture of HAIs in Virginia. We look forward to using these data and working with our partners to prevent HAIs.

In this issue:

Upcoming Events:

September 25: Updated state HAI reporting regulations go into effect

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

October 18-24: International Infection Prevention Week

Contact:

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

Core Elements of Antibiotic Stewardship in Nursing Homes

This month, the Centers for Disease Control and Prevention (CDC) released a new document to help expand or initiate antibiotic stewardship activities in nursing homes. The CDC outlines seven core elements that are necessary to implement successful antibiotic stewardship programs in nursing homes.

The elements are:

- Leadership commitment
- Accountability
- Drug expertise
- Action
- Tracking
- Reporting
- Education

The core elements are the same as those from the CDC Core Elements of Hospital Antibiotic Stewardship but their suggested implementation has been adapted to better reflect the staffing/resources in nursing homes and long-term care facilities. The CDC recommends that facilities select one or two elements to implement initially according to their baseline needs and to gradually add activities as stewardship goals are met.

An accompanying checklist is provided to guide facilities in performing the initial baseline assessment. To view the checklist, visit: **http://www.cdc.gov/longtermcare/pdfs/core-elements-antibiotic-stewardship-checklist.pdf**

To view the full list of core elements and activities, please visit: **http://www.cdc.gov/longtermcare/prevention/antibiotic-stewardship.html**

International Infection Prevention Week: October 18-24, 2015

The Association for Professionals in Infection Control and Epidemiology, Inc. (APIC) invites you to recognize International Infection Prevention Week, **October 18-24, 2015**, and join in the activities surrounding this important week. This year's theme is **promoting engagement between patients, visitors, and healthcare professionals around infection prevention.**

APIC President Mary Lou Manning, PhD, CRNP, CIC, FAAN, FNAP notes the number one way to prevent infection is hand hygiene and reminds consumers to speak up by asking their healthcare providers if they have washed their hands. Proper infection control practices are necessary to prevent extended hospital stays, complications, and deaths each year.

Recognizing that we can have a safer world through infection prevention, APIC has designed a pledge of support for steps to prevent infection as healthcare professionals and as a consumer of healthcare. APIC has created numerous **free** educational tools and resources to support the goals of the infection prevention pledge focusing on hand hygiene, judicious use of antibiotics, appropriate immunizations, safe injection practices, using personal protective equipment, and sharing accurate information. Visit **http://www.apic.org/** to access the pledge and resources.

Join the #IIPWChat on Wednesday, October 21 at 12 p.m. EDT to learn more about how to prevent infections! The Twitter chat hosted by the American Hospital Association and APIC will focus on how patients and healthcare providers can work together to reduce HAIs with a focus on hand hygiene, influenza vaccination, and antibiotic stewardship.

Remember, infection prevention starts with YOU!

Supplemental Reprocessing Measures for Gastrointestinal Endoscopes

According to a recent study conducted by researchers from Ofstead and Associates and Mayo Clinic, gastrointestinal endoscopes often harbor viable microbes and biologic debris, despite undergoing a multi-step process of cleaning and disinfection.

Researchers tested samples during 60 encounters with 15 colonoscopes and gastroscopes, which were all reprocessed according to appropriate guidelines. To assess contamination levels, samples were collected and tested after each step in the cleaning process (bedside cleaning, manual removal, automated endoscope reprocessing with a high-level disinfectant, and overnight storage). Viable microorganisms were detected from bedside-cleaned (92%), manually-cleaned (46%), high-level disinfected (64%), and stored (9%) endoscopes. These findings suggest that current practices for detecting and removing "residual contamination" on endoscopes are not sufficient.

Though the researchers believe that all of the organisms present after the high-level disinfectant and storage were unlikely to cause patient harm (due to the low pathogenicity and concentration of the microbes identified), the presence of *any* organism after cleaning indicates flaws with the standard disinfection process. This could lead to contamination and transmission of pathogenic organisms to patients, sometimes resulting in multidrug-resistant infections.

Following an increase of endoscope-associated infections, especially among duodenoscopes, the Food and Drug Administration (FDA) has created a list of supplemental duodenoscope reprocessing measures intended to be combined with manufacturer's instructions for infection prevention. The additional measures include microbiological culturing, ethylene oxide sterilization, use of a liquid chemical sterilant processing system, and repeat high-level disinfection.

The FDA notes that not all healthcare facilities will be able to implement some of the additional measures, but the benefits of using these devices in medical procedures "continue to outweigh the risks." The FDA reminds staff responsible for reprocessing tools to follow strict adherence to manufacturer instructions.

To read the entire study, visit: **http://www.ajicjournal.org/article/S0196-6553(15)00148-0/pdf**

To view the FDA list of supplemental reprocessing measures, visit: **http://www.fda.gov/MedicalDevices/Safety/AlertsandNotices/ucm454766.htm**

CDC Health Advisory: Review Practices for Reprocessing Medical Devices

On September 11th, the CDC issued a Health Advisory (**http://emergency.cdc.gov/han/han00382.asp**) alerting healthcare providers and facilities about the "public health need to properly maintain, clean, and disinfect or sterilize reusable medical devices." Inpatient and outpatient healthcare facilities that utilize reusable medical devices are urged to review current reprocessing practices to assure they are complying with manufacturers' directions and have appropriate policies and procedures in place that are consistent with current standards and guidelines.

Several actions involving training, audit and feedback, and infection control policies and procedures are recommended to ensure device reprocessing is done correctly. Healthcare facilities should:

- Provide training to all personnel who reprocess medical devices, including upon hire, annually, and when new devices or protocols are introduced.
- Monitor and document adherence to cleaning, disinfection, sterilization, and device storage procedures regularly. Personnel should receive feedback from the results of these audits.
- Allow adequate time for reprocessing to ensure adherence to all steps outlined by the device manufacturer.
- Ensure healthcare personnel can readily identify devices that have been properly reprocessed and are ready for patient use.
- Have policies and procedures in place to outline facility response in the event of a recognized reprocessing error or failure.
- Maintain documentation of reprocessing activities.
- Follow manufacturer recommendations for maintenance and repair of medical devices that are used to perform reprocessing functions as well as medical devices that are reprocessed.

Updated Ebola Personal Protective Equipment Guidance

On August 27th, the CDC released updated guidelines regarding personal protective equipment (PPE) for healthcare workers managing patients suspected or confirmed to have Ebola virus disease.

The Ebola PPE update clarifies and provides more detail than previous versions, specifically by:

- Expanding the rationale for respiratory protection
- Clarifying the role of the trained observer (observer should **not** assist in doffing PPE)
- Suggesting that a designated "doffing assistant" be present
- Modifying the powered air purifying respirator (PAPR) procedure to enhance clarity
- Changing the order of boot cover removal; boot covers should now be removed **after** the gown
- Recommending the selection of certain types of gowns and coveralls
- Emphasizing frequent cleaning of the floor and work surfaces in the doffing area

By incorporating these updated guidelines into infection control and safety training, healthcare facilities that are capable of providing care to patients with suspected or confirmed Ebola can offer better protection to both healthcare workers and patients.

To read the entire updated guidance document visit: **http://www.cdc.gov/vhf/ebola/healthcare-us/ppe/guidance.html**

For any questions about Ebola and PPE, visit the Frequently Asked Questions page: **http://www.cdc.gov/vhf/ebola/healthcare-us/ppe/faq.html**

CDC Raising Sepsis Awareness

The CDC recently released a series of fact sheets aimed to raise sepsis awareness during September, the time period designated as Sepsis Awareness Month. Sepsis is the body's overwhelming and life-threatening response to infection which can lead to tissue damage, organ failure, and death. Prompt identification and treatment is essential to decrease the risk kof complications and death.

The first sepsis fact sheet provides general information, including causes, symptoms, treatment, and prevention. In the second fact sheet, the CDC discusses the link between cancer and sepsis, explaining why cancer patients are more likely to develop sepsis. The third fact sheet provides information for survivors of sepsis, including recovery and potential long-term effects.

In addition to the fact sheets, the CDC also published several posts regarding sepsis on its Safe Healthcare Blog. In one blog post, Georgia nurse Susan Irick detailed her personal experiences with sepsis. As a two-time survivor of this life-threatening reaction to infection, Irick believes awareness is crucial. She urges both patients and healthcare workers to become familiar with the signs of sepsis, in the hopes of prompting timely diagnosis and treatment. Other topics of blog posts included promoting community and healthcare clinician awareness, the role of EMS in identifying pediatric sepsis, healthcare costs associated with sepsis, the role of home care in early sepsis recognition, and several other personal stories of experiences with sepsis.

To view the CDC sepsis fact sheets, visit: **http://www.cdc.gov/sepsis/basic/index.html**

To access the sepsis posts on CDC's Safe Healthcare Blog, visit: **http://blogs.cdc.gov/safehealthcare**

Acute Flaccid Myelitis: Continued Vigilance Required

August through October of 2014 saw an increase in cases of acute flaccid myelitis (AFM) with a total of 120 cases in children from 34 states. This coincided with an increase in cases of enterovirus D68 (EVD-68). While the two were not etiologically linked, the timing prompted the CDC to investigate, change the case definition for AFM, and request increased surveillance for future cases. Last year, the illness presented with acute onset of limb weakness, often in combination with an elevated white blood cell concentration in cerebrospinal fluid (CSF) or an abnormal MRI. Onset usually followed a respiratory or febrile illness with less than 20% of AFM cases diagnosed with EVD-68.

The CDC has recommended that physicians increase vigilance for cases of AFM and continue reporting cases of AFM to the local health department.

As of August 1, 2015, a revised case definition has been adopted. The new definition has been broadened to include all ages, noting that some viral infections are more likely to cause AFM in adults, and by allowing CSF findings to lead to *probable* case status, noting that not all patients receive MRIs and that an MRI may be normal if conducted too soon after onset. The new definitions assign *confirmed* case status to those with acute focal limb weakness and an MRI that shows a spinal cord lesion largely contained in the central gray matter. A *probable* case is now one that presents with acute focal limb weakness and CSF showing pleocytosis (white blood cell count >5 cells/mm^3).

Clinicians are asked to report AFM classified as confirmed or probable to the health department. Early specimen collection is advised and includes CSF, whole blood, serum, stool, and respiratory specimens. Please consult with your local health department for more information.

Updated AFM guidance for clinicians and health departments including specimen collection and clinical care guidance is available on the CDC website: **http://www.cdc.gov/ncird/investigation/viral/2014-15/index.html**

Urinalysis Overuse Inflates Antibiotic Orders for Elderly

In a recent study published in *JAMA Internal Medicine*, researchers have linked indiscriminate urinalysis testing with antibiotic prescriptions in asymptomatic, elderly hospital patients. The study design consisted of tracking a cohort of consecutive patients aged 75 or older (N=403) who were admitted to the general medicine service from the emergency department. The data collected included age, sex, whether the patient resides in long-term care, and the presence of diabetes, dementia, or three or more comorbidities. The researchers observed the patients for urinalysis indicators (urinary tract infection symptoms or acute kidney injury), orders for urinalysis, orders for urine cultures, and prescription rates of antibiotics based on urine culture results. The results found that of the 250 patients (62%) who underwent urinalysis, 198 were missing the UTI symptoms or acute kidney injury considered to be indicators for testing. The three most common chief complaints among those tested asymptomatic patients were falls (N=33), fever, non-urinary source (N=28), and chest pain (N=27). Positive urinalysis results were closely correlated with both orders for urine culture and antimicrobial prescription ($p<0.001$). The researchers concluded that the overuse of urinalysis in elderly patients leads to antimicrobial prescription in asymptomatic patients. By decreasing reliance on urinalysis, facilities could improve their urine culture and antimicrobial prescribing practices to promote antimicrobial stewardship.

To view the article (prescription required): **http://archinte.jamanetwork.com/article.aspx?articleid=2429104**

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

For additional information please contact:

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