SYNERGY: COMBINING EFFORTS FOR HAI PREVENTION

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

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Edited by: Andrea Alvarez

Notes from VDH

To hospitals with adult intensive care units–if you have not done so in the past two weeks, **please re-confer rights to the Virginia Department of Health** so we can continue to monitor central line-associated bloodstream infection data as mandated per state regulations. We ask you to re-confer rights because of a glitch with NHSN when the new version was installed earlier this year. Thank you! Please let Andrea Alvarez know if you have any questions or problems conferring rights.

We also hope many of you were able to take advantage of the webstreaming NHSN training offered by the Centers for Disease Control and Prevention earlier this month. The three days of training were jam-packed and included lots of helpful tips on how to apply the new 2015 surveillance definitions. If you missed it, the slides and archived trainings will be available on the CDC website in the coming weeks. We will let you know when they are posted and how to access the trainings!

CRE Outbreak Linked to Duodenoscopes

A large carbapenem-resistant Enterobacteriaceae (CRE) outbreak in a Los Angeles hospital is focusing the spotlight on the reprocessing of endoscopic retrograde cholangiopancreatography endoscopes (also known as duodenoscopes) in healthcare settings. At least 7 cases of CRE have been identified in this outbreak, two of whom died, and nearly 180 patients may have been exposed to CRE. Reprocessing is a detailed, multistep process to clean and disinfect or sterilize reusable devices.

Duodenoscopes are used to evaluate and remove blockages from the bile and pancreatic ducts that drain a patient's liver. These medical devices are more intricate than other endoscopes and can be difficult to clean and disinfect. In this outbreak, there was no breach in reprocessing procedures and no evidence of defects in the duodenoscopes themselves.

In response, the Food and Drug Administration (FDA) has issued a safety alert to raise awareness that the complex design of these devices may impede effective reprocessing. Following manufacturer reprocessing instructions correctly may still not eliminate all risk of infection transmission. To read the safety alert and see more recommendations, go to: http://www.fda.gov/MedicalDevices/Safety/AlertsandNotices/ucm434871.htm).

The CDC continues to work with FDA and others on the optimal protocols for endoscope reprocessing. Until more is known, it is important for facilities to strictly follow manufacturer guidelines, particularly manual cleaning and drying, and to also be aware of the potential risk of CRE transmission.

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March 8-14: Patient Safety Awareness Week

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

The Burden of *Clostridium Difficile* in the United States

The February 26th issue of the *New England Journal of Medicine* features an article with updated estimates of *Clostridium difficile* infection (CDI) in the United States. This study estimated that *C. difficile* caused approximately 453,000 incident infections and was associated with approximately 29,000 deaths in the United States in 2011. Since the mortality that is attributable to *C. difficile* infection is about 50% of the crude mortality, the study estimated the total number of deaths that are attributable to CDI annually to be about 15,000. Less than two-thirds (65.8%) were healthcare-associated, but approximately one-quarter (24%) had onset during hospitalization. This equates to an estimated 107,600 hospital-onset infections nationally, which is higher than a recent point-prevalence survey from a similar time period. These findings emphasized that the prevention of CDI should go beyond hospital settings; 46% were community-associated and had no documented inpatient healthcare exposure. Approximately one-fifth (21%) of healthcare-associated *C. difficile* infections and 14% of community-associated infections had at least one recurrence of illness.

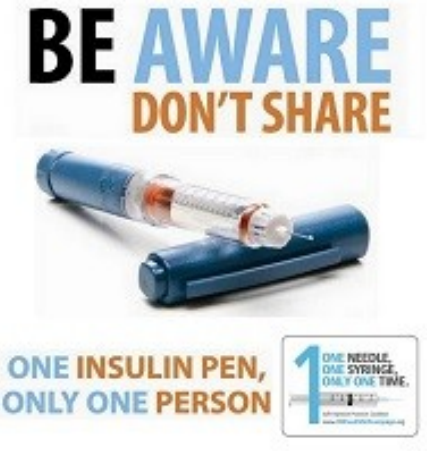
To read the full article in *NEJM*, go to: http://www.nejm.org/doi/full/10.1056/NEJMoa1408913

To coincide with the *C. difficile* study release, CDC released a new infographic that outlines the impact, risk, spread, and prevention of CDI (http://www.cdc.gov/media/pdf/dpk/2015/dpk-deadly-diarrhea/cdiff-one-pager.pdf).

New FDA Label Warnings to Prevent Sharing of Multi-Dose Injectable Diabetes Medicines

Earlier this month, the FDA issued a requirement for additional label warnings on multi-dose injectable diabetes medications. These medications will have a warning label on the insulin pen and on the pen carton stating "for single patient use only" to emphasize that these insulin pens should *never* be shared among patients, even if the needle is changed. To minimize medication errors in healthcare facilities, insulin pens should be clearly labeled with each patient's name or other identifying information. Sharing pens can result in the spread of infections from one person to another. Additional warnings will be added to the prescribing information and to the patient Medication Guides, Patient Package Inserts, and Instructions for Use.

To read the safety announcement, go to: http://www.fda.gov/Drugs/DrugSafety/ucm435271.htm



Patient Safety Awareness Week: March 8-14, 2015

Patient Safety Awareness Week is an annual education and awareness campaign led by the National Patient Safety Foundation. 2015's campaign runs March 8-14 and the theme is "United for Safety." Everyone in the healthcare process – patients, care providers, and administrators – are all united in the goal of keeping patients/residents and their healthcare providers free from harm. The campaign aims to promote patient engagement and emphasize the importance of the relationship between patients/residents and their families.

Please consider promoting this campaign in your organization or healthcare facility and think about how you can encourage better communication between healthcare providers and patients/residents.

Educational resources and tools are available on the Patient Safety Awareness Week website: http://www.npsf.org/?page=awarenessweek