



# SYNERGY: COMBINING EFFORTS FOR HAI PREVENTION



June 2013

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

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Edited by:  
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## Notes from VDH

Thank you for entering your CLABSI data for 2013Q1 (January-March); all facilities submitted all three months of data from their adult intensive care units! Virginia facilities observed 48 CLABSIs and 49,659 central line days in their adult intensive care units and had a SIR of 0.52. This translates to Virginia's hospitals experiencing 48% fewer infections than predicted when compared to the

## APIC Conference Recap

The Association for Professionals in Infection Control and Epidemiology (APIC) Annual Conference took place June 8-10<sup>th</sup> in Fort Lauderdale, FL. The conference celebrated its 40<sup>th</sup> anniversary and opened with highlights from 12 all-stars in infection prevention spanning the last four decades. Addressing milestones, challenges, and progress in the field of infection prevention, the panel spoke to an audience of more than 2,500 clinical professionals representing healthcare practice settings in the U.S. and abroad.

Over 100 educational sessions and 300 plus poster presentations provided updates on the latest in infection prevention science, research, and interventions allowing attendees to expand their networks and learn about evidence-based advances in infection prevention. Hot topics at this year's conference included: safe injection practices highlighting the 2013 APIC Film Festival winner, CDC's One & Only Campaign video [www.youtube.com/watch?v=6D0stMoz80k&feature=player\\_embedded](http://www.youtube.com/watch?v=6D0stMoz80k&feature=player_embedded); infection prevention during disaster management; outbreak investigations including the recent multistate fungal infections associated with contaminated

baseline U.S. experience. The U.S. Department of Health and Human Services' National HAI Action Plan goal for CLABSI is a 0.50 SIR by the end of 2013. Our hospitals are well on their way (and have even achieved a lower SIR in some previous quarters), but we can even do better! Keep up the good work and encourage others to spread the epidemic of infection prevention!

steroid medication; environmental cleaning toolkit and best practices; effective ways to present statistics; NHSN surveillance definitions; horizontal vs. vertical interventions in prevention of healthcare-associated infections; and APIC's first-ever simulation session: *Collaboration Between the Perioperative Nurse and Infection Preventionists*.

To view more about the APIC 2013 conference proceedings, please visit: <http://ac2013.site.apic.org/>.

During the conference, APIC recognized the 2013 Heroes in Infection Prevention who have designed and implemented infection prevention practices in their settings and beyond to improve health outcomes. The profiles and contributions of the 12 recognized heroes may be viewed by visiting the heroes of infection prevention web page: [www.apic.org/heroes](http://www.apic.org/heroes).

The closing keynote address titled "Viral Forecast for Pandemic Prevention" featured Dr. Nathan Wolfe, award winning-epidemiologist, and author of *The Viral Storm: The Dawn of a New Pandemic Age*.

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## Upcoming Events:

### July 17 (12-1PM):

CRE webinar sponsored by colleagues in North Carolina

### October 9:

APIC-Virginia Pre-Conference (CIC Review)—Richmond

### October 10-11:

APIC-Virginia Annual Conference—Richmond

## Contact:

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## CSTE Conference Recap

The Council of State and Territorial Epidemiologists (CSTE) Annual Conference was held June 9-13th in Pasadena, CA. The conference covered a wide range of public health topics from foodborne illness to chronic disease and many sessions featured presentations on HAI surveillance and prevention. A pre-conference HAI workshop included a tabletop exercise on a cluster of joint infections in an outpatient surgery clinic, discussions of how different states present their HAI data to the public, carbapenem-resistant Enterobacteriaceae (CRE) surveillance, and HAI data analysis. HAI breakout sessions included topics such as outbreak investigations in long-term care facilities and outpatient settings, establishing HAI surveillance in non-acute settings, data validation, engaging local health departments for infection prevention, and the hepatitis C investigation of an allied health professional who diverted drugs and transmitted hepatitis to patients in multiple states.

## Recent Publications on Patient Education & Engagement

The June 2013 issue of the *American Journal of Infection Control* featured two articles on patient education and engagement. A literature review by Burnett and colleagues found that the public generally believes people are at high risk of contracting healthcare-associated infections (HAI). However, there is a lack of understanding about how an infection is caused, transmitted, and treated. Many cited the media as a main source of information, while acknowledging media information as often inaccurate. Personal experience and experiences of others were also important in shaping perceptions of risk. How and why people form risk perceptions of acquiring HAIs shapes their attitudes towards health care and their willingness to take action. To access this article, go to: [www.ajicjournal.org/article/S0196-6553\(12\)00972-8/abstract](http://www.ajicjournal.org/article/S0196-6553(12)00972-8/abstract).

## Updates from the Department of Health & Human Services

An updated version of the *National Action Plan to Prevent Health Care-Associated Infections: Road Map to Elimination* was recently published and builds upon the original version released in 2009 by expanding with new sections that address increased influenza vaccination of healthcare personnel, and infection prevention in long-term care facilities, ambulatory surgical centers, and end-stage renal disease facilities. To read more about the Updated National HAI Action Plan: [www.hhs.gov/ash/initiatives/hai/actionplan/index.html](http://www.hhs.gov/ash/initiatives/hai/actionplan/index.html).

CDC staff also discussed changes planned for upcoming versions of NHSN, which include:

- August 2013 release
  - Healthcare personnel flu vaccination reporting will modify required time working in the facility from 30 days to “at least one day”
  - SummaryYH will be a time period option for all analyses (where applicable)
  - Updated statistics calculator
- January 2014 release
  - Building a web-based LabID calculator (similar to the VAE calculator) - estimated January 2014
  - Add alerts and analysis reports for resistant organisms of concern (e.g., CRE)
  - Changes to procedure and SSI definitions and form requirements (e.g., add diabetes, weight, height, and closure type for all procedures)

In a study conducted in the pediatric hospital setting, the majority of parents of pediatric patients surveyed felt they had a role in helping prevent HAIs and correctly perceived healthcare workers' (HCW) hand hygiene as the most important HAI prevention practice. While ¾ of parents were willing to help improve HCW hand hygiene, few were willing to remind a HCW to wash his/her hands. However, there was a significant increase in willingness to remind HCWs if the HCW invited parents to do so. It is important to look at what factors encourage or deter active patient engagement. To read more about this study, go to: [www.ajicjournal.org/article/S0196-6553\(12\)01159-5/abstract](http://www.ajicjournal.org/article/S0196-6553(12)01159-5/abstract).

On May 20<sup>th</sup>, eight hospitals were awarded HHS-Critical Care Societies Collaborative Awards to recognize achievements in eliminating HAIs. These hospitals were successful in significantly reducing or eliminating catheter-associated urinary tract infections, central line-associated bloodstream infections, or ventilator-associated pneumonia. In addition, 11 healthcare facilities were given honorable mentions for their steps to prevent HAIs. To see a full list of the awardees: [www.hhs.gov/ash/initiatives/hai/projects/index.html#awards\\_program](http://www.hhs.gov/ash/initiatives/hai/projects/index.html#awards_program).

## NHSN Q&A

**Question:** Is there a national or state requirement to report Ventilator Associated Events (VAE) to NHSN?

**Answer:** No. However, if you are participating in the NoCVA HEN HAI Learning Network (in which case you're encouraged to confer rights to the NoCVA HEN for all 4 HAIs covered in the Learning Network – SSI, CLABSI, CAUTI, and VAP) then you would report VAE to NHSN. To be in compliance with NHSN reporting protocols, if you *do* report to NHSN, you have to do so for at least one month in a year. Again, that is voluntary participation and not related to state or federal reporting requirements.

**Question:** A patient is admitted on 6/1/13 (to unit A) and then transferred to unit B on 6/5/13. A positive *C. difficile* specimen was collected on 6/10/13. When entering into NHSN, is the location assigned to unit A (primary admission) or unit B (where specimen collected)?

**Answer:** Enter the inpatient care unit/location where the patient was assigned when the laboratory-identified MDRO or *C. difficile* event specimen was collected. Regarding the "date admitted to location" field: enter the date the patient was admitted to the inpatient care unit/location where laboratory-identified monitoring is being performed and where the specimen was collected from the patient. In this scenario, enter the location where the specimen was collected as unit B, and the date of admission to unit B. ([http://www.cdc.gov/nhsn/forms/instr/57\\_128.pdf](http://www.cdc.gov/nhsn/forms/instr/57_128.pdf))

## CDC Patient Notification Toolkit

Since 2001, more than 150,000 patients have been potentially exposed to hepatitis B and C viruses and HIV due to unsafe medical practices in U.S. healthcare facilities.

The Centers for Disease Control and Prevention (CDC) released a new toolkit to assist health departments and healthcare facilities with notifying patients after an infection control lapse or potential disease transmission during medical care (whether or not disease transmission has occurred). It offers resources and template materials

to facilitate the notification process as well as some essential tips and strategies. These situations have the potential to be high profile, sensitive, and fear-inducing; this toolkit contains resources and templates to facilitate a swift and effective notification process. These tools include template letters and focus groups results regarding what patients want to read in a notification letter. Note that the toolkit does not cover how to assess whether a patient notification is warranted. The toolkit is available online at: [www.cdc.gov/injectionsafety/pntoolkit/index.html](http://www.cdc.gov/injectionsafety/pntoolkit/index.html)

## CDC Grand Rounds: Preventing Unsafe Injection Practices

Outbreaks caused by unsafe injections have increased in recent years due to mishandling of medications and reusing equipment designed for single-use. Reusing syringes when accessing shared medication vials often causes outbreaks, as does reusing single-dose medication vials for multiple patients. In an 2008 outbreak of hepatitis C virus (HCV) in Nevada, nurses were reusing single-dose vials of propofol on multiple patients, and using clean needles with dirty syringes. When a patient with HCV was injected, the syringe became contaminated by backflow so that when the nurse accessed the medication vial for another dose, even when using a clean needle, the medication would become contaminated as well. When the same single-dose vial was then used on multiple patients, the contaminated medication transmitted HCV to other patients.

Policy must also correspond with education in order to ensure infection prevention and safety procedures are followed. A 2008 state law in New York enabled health departments to have greater ability to investigate physicians for poor infection control. To prevent unsafe injection practices, public health departments and facilities should follow the four "E's":

- (1) Epidemiological surveillance, reporting, monitoring, and investigation of outbreaks potentially related to unsafe injections.
- (2) Educational initiatives to promote understanding and use of safe injection and basic infection control practices.
- (3) Enforcement and oversight by federal and state authorities.
- (4) Engineering of devices, equipment, and processes to reduce or eliminate disease transmission risks.

To read the full CDC report, go to: <http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6221a3.htm>.

## Save the Date

Wednesday, July 17, 2013

12—1 PM

For a *free* educational webinar on carbapenem-resistant *Enterobacteriaceae* (CRE)

- What is CRE?
- Why are these organisms important?
- What are some prevention strategies?

These and other questions will be answered during the webinar presented by:

**Katie Passaretti, MD**, Infectious Diseases and Internal Medicine, Hospital Epidemiologist,  
Carolinas Metro Facilities, Charlotte, NC

**Target Audience:** All healthcare providers in all care settings.

### Goal and Objectives:

- Goal – To introduce and educate as many varied healthcare staff as possible on CRE
- Objective 1 - Describe the epidemiology of CRE in the US
- Objective 2 – Review measures necessary to halt transmission
- Objective 3 – Understand the importance of a regional approach to CRE control

### Sponsored By:

- North Carolina Quality Center (NCQC)
- The Association for Professionals in Infection Control and Epidemiology – North Carolina Chapter (APIC-NC)
- The Statewide Program for Infection Control and Epidemiology (SPICE)
- The North Carolina Division of Public Health (DPH)

**To register for this webinar, go to:**

<https://qcwebinar.webex.com/qcwebinar/onstage/g.php?t=a&d=662312650>

For those unable to participate in the live webinar, it will be recorded and archived on the NCQC website so that it may be viewed at a later date.

**APIC Virginia Chapter Annual Educational Conference and Pre-Conference**  
**“Capital Gain . . . Investing in Our Future”**  
**Pre-Conference: CIC Review**

**Date:** Pre-conference: Wednesday, October 9, 2013 (8 – 4:30)  
Conference: Thursday and Friday, October 10-11, 2013

**Time:** Registration begins at 7:00 am each day

**Location:**

Embassy Suites Conference Center  
2925 Emerywood Parkway  
Richmond, VA 23294  
Phone: (804) 672-8585  
Website: [www.embassysuites.com](http://www.embassysuites.com)

**Room Rates:** King Suite \$119.00 \* or Double Suite \$139.00 \*

\* Plus 13% Sales Tax

Room rates effective thru 9/17/13

**Registration Fees:**

**Pre-conference:** Early Bird APIC-VA Member: \$150.00 (By 9/17/13)  
Member \$175.00 (After 9/17/13)  
Non-Member \$200.00

**Conference:** Early Bird APIC-VA Member: \$200.00 (By 9/17/13)  
Member \$235.00 (After 9/17/13)  
Non-Member \$255.00  
Thursday Only \$175.00  
Friday Only \$145.00

**Refund requests must be submitted in writing and rec'd by 9/17/13 for full refund**

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