ADHS

HAI HAPPENINGS

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www.preventHAlaz.org
HAI Happenings

• HAI Coordinator Update
• CDC Patient Notification Toolkit
• HAI Subcommittee Update
• ADVICE Collaborative
• What is Next?
HAI Coordinator Update

• Position description has been revised and updated.
• Updated position has been submitted to Human Resources.
• Position should be posted to www.AZStateJobs.gov in the near future.
Is a Patient Notification Toolkit Needed?

- Possible multi-county exposure to BBP through compromised dental equipment.
- Initial public health concern for community.
- Investigation initiated with notification and involvement of numerous public health partners.

**How will we notify possibly affected patients?**
Patient Notification Toolkit

• The CDC recently introduced a helpful toolkit to assist health departments and healthcare facilities when patient notification is needed due to an infection control lapse or disease transmission.

• This toolkit helps provide a template for consistent communication that can be completed quickly in these sensitive incidents.

• More information can be found at: http://www.cdc.gov/injectionsafety/pntoolkit/index.html
Patient Notification Toolkit

• The toolkit consist of 4 sections:
  – **Section 1: Developing Documents for a Patient Notification**
    • Sample materials
    • Additional resources
    • What patients expect to see in a notification letter
    • Guiding principles of risk communication
  – **Section 2: Planning Media and Communication Strategies**
    • Tips
    • Sample materials
    • Resources
Patient Notification Toolkit

– **Section 3: Establishing Communication Resources**
  • Frequently asked questions resources
  • Setting up a call center

– **Section 4: Best Practices in Conducting Patient Notifications**
  • When to notify patients
  • Communicating with key stakeholders and partners
  • Notification events and prevention opportunities
HAI Subcommittee Updates
Antimicrobial Stewardship Subcommittee

- MDRO Fact Sheet
  - Possibly the first of a many

- Antibiogram Toolkit
  - Developing Cumulative Susceptibility Reports for Your Clinicians and Ensuring Their Appropriate Interpretation and Effective Use

Multidrug-Resistant Organisms (MDRO)

What is an MDRO?
- MDRO are microorganisms resistant to multiple agents in one or more classes of antimicrobial agents.
- MDRO are highly resistant bacteria including but not limited to: Methicillin-resistant Staphylococcus aureus (MRSA), carbapenem-resistant Enterobacteriaceae (CRE), Gram negative bacilli (GNB) including Escherichia coli, Klebsiella pneumoniae, Acinetobacter baumannii, and Burkholderia cepacia.
- Resistance can occur by multiple mechanisms depending on the type of organism.

What is the clinical impact of an MDRO?
- MDRO can easily be transferred among patients.
- Many MDRO can be difficult to treat.
- Patients with MDRO are at a greater risk of developing poor health outcomes.

Who is at risk?
- Patients receiving long or repeated courses of antibiotics.
- Patients with prolonged medical care.
- Immunocompromised patients.
- Patients with indwelling medical devices such as urinary catheters, endotracheal tubes or central venous catheters.
- Patients who received inappropriate, excessive, or incorrectly administered antibiotics.

What is being done to identify patients with infections caused by MDRO?
- The Microbiology department performs cultures to identify organisms and susceptibilities as necessary.
- If an organism is confirmed as MDRO the patient’s facility is notified.
- Patients identified with MDRO are placed under appropriate isolation precautions.
- An alert should be placed in the patient’s record to indicate that appropriate isolation precautions need to be used.
- An appropriate transfer tool should be employed to communicate infections across healthcare facilities.

What can be done to prevent the spread of MDRO?
- Strict hand hygiene and appropriate isolation precautions are key to prevent the spread of MDRO.
- Provide patient education about MDROs.
- For more information on steps to MDRO prevention and control, check out the CDC’s Management of Multidrug-Resistant Organisms in Healthcare Settings, 2006.

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Healthcare-Associated Infections (HAI) Program
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Antimicrobial Stewardship Subcommittee

• Antibiotic Stewardship Slide Set
  – Working to Improve the Use of Antibiotics in the Hospital and Community

“Antibiotics are a gift to us from prior generations and that we have a moral obligation to ensure that this global treasure is available for our children and future generations.”

Surveillance Subcommittee

- NHSN Fact Sheet
  - Use of National Healthcare Safety Network (NHSN) by Skilled Nursing Facilities for Infection Surveillance and Prevention
Long Term Care Work Group Subcommittee

• Post-assessment of Arizona Department of Health Services (ADHS) HAI Advisory Committee recommendations that long-term care facility staff use the Enhanced Standard Precautions for Long-Term Care Facilities.
Long Term Care Work Group Subcommittee

Transfer Tool

• The goal of this tool is to aid in the communication between hospitals and skilled nursing facilities in regards to infection control.

Interfacility Infection Prevention Transfer Tool

Name: 
Date of transfer: 
Was the patient in isolation on date of discharge/transfer?  
□ Yes □ No 
Type of precautions/isolation:  
□ Contact □ Droplet □ Airborne 

<table>
<thead>
<tr>
<th>Infectious agent</th>
<th>Site of infection</th>
</tr>
</thead>
<tbody>
<tr>
<td>Methicillin-resistant Staphylococcus aureus (MRSA)</td>
<td></td>
</tr>
<tr>
<td>Vancomycin-resistant Enterococcus (VRE)</td>
<td></td>
</tr>
<tr>
<td>Clostridium difficile (C. diff)</td>
<td></td>
</tr>
<tr>
<td>Other active communicable disease, Specify</td>
<td></td>
</tr>
</tbody>
</table>

Comments:

*Surveillance of infections is key to effective infection control. Therefore having a tool that assists in communication between facilities during transition of care is essential. This tool is intended to improve patient and employee safety and to help the receiving facility know how to prepare for the patient’s arrival.

How to use this tool:

• This tool should be used with every patient transfer.
• Indicate the isolation status of the patient upon discharge.
• Place the tool on the very top of the patient’s paperwork packet.
Prevention Strategies Subcommittee

• Recently completed first ever ADHS CAUTI Boot Camp!
  – Provide open forum
  – Attended by 5 CAH
  – Hit target audience

• Subcommittee is now focusing efforts:
  – To address other Healthcare-Associated Infections (HAI)
  – Working with other subcommittees to maximize prevention efforts and programs

Save the Date for CAUTI Boot Camp

Let’s stomp out infection!

June 12, 2013
1-2pm webinar

Open forum, ask the experts!
Infection Prevention, CMS, ADHS Licensing Dept

Call-in Number: 1-805-399-1200
Participant Access Code: 759953
If you would like to follow along online, please visit: https://azdhs.ilinc.com/join/pHMhVZ

- What is a CAUTI?
- How does CAUTI relate to you?
- Patient safety through CAUTI prevention
- Reimbursement- Facts or Fiction

Send in your anonymous CAUTI questions so we can tailor our presentation to your needs: https://www.surveymonkey.com/s/CAUTIFAQ

Check out our website: www.preventhalaz.org
Training and Education Subcommittee

- Pertussis Pamphlet

- Organizing an International Infection Prevention Week (IIPW) Poster Contest
  - Focus on the history of vaccines!
ADVICE Collaborative

• May 17th, 2013
• To build strategic partnerships with dialysis providers, ESRD networks, renal associations, public health professionals, federal partners, and other stakeholders.
• Hoped to stimulate significant improvement in infection control in dialysis care.
ADVICE Collaborative

- Participants discussed
  - current best practices
  - new ways to promote infection control
  - developed a strategic plan of future activities

What is Next?

- ADHS ESRD Subcommittee
Thank you

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