

CDPHE

POINTS OF INTEREST

- ◆ Please notify the Patient Safety Program about any changes and/or additions to Infection Preventionists' (IP) email addresses. Notifications should be sent to: Sara.Reese@state.co.us
- ◆ As a reminder, data entry into the National Healthcare Safety Network (NHSN) is the responsibility of the IP. Patient Safety Program staff are available for NHSN data analysis, technical support and inquiries.
- ◆ On Dec. 1, the Patient Safety Program will pull infection data from Aug. 2010—Jul. 2011 to compile the yearly "State of Colorado Status Report on the Health Facility—Acquired Infections Disclosure Initiative" report. All data for the reporting period must be entered prior to this date.
- ◆ Any hospital with an inpatient prospective payment system (PPS) rehabilitation unit will begin tracking and monitoring of Central Line Associated Blood Stream Infection (CLABSI) data effective Jan. 1, 2012. Letters of notification to CEOs and IPs were sent out this month.

On behalf of the Patient Safety Program and the HAI Epidemiology Team, we would like to wish you and yours a very happy, healthy, and safe holiday season!

The HAI Hub

A Quarterly Publication by the Patient Safety Program & Healthcare-Associated Infections (HAI) Epidemiology Team

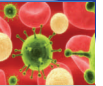
VOLUME 1, ISSUE 2



Colorado Department
of Public Health
and Environment
WINTER 2011



Spotlight: IP Champion—Susan Dolan



1. When you are not fighting infections or promoting hand washing in hospitals/other facility types, what do you enjoy doing most?

Golfing and downhill skiing at Copper Mountain with family and friends.

2. What words of wisdom would you pass on to the infection prevention community?

I would tell IPs to be persistently observant and go beyond the daily tasks of regular and expected requirements. Make the effort and be persistent with investigating something that doesn't seem right because this might provide an opportunity to fix something. The time spent investigating the obvious and not so obvious can be well worth the effort. Nothing in an investigation should be off limits. Most of all, listen to the experts at the unit and department level.

3. During your time in the world of infection control, what was your most rewarding experience?

My most rewarding experience has to be working with the epidemiology team and with amazing mentors here at Children's Hospital Colorado. During my time in infection control, I have had the opportunity to network and expand my horizons at the national level with the Association for Professionals in Infection Control and Epidemiology (APIC) and other groups such as the Centers for Disease Control and Prevention (CDC), Safe Injection Practices, and Premier, etc. I would also like to add that Children's Hospital Colorado and colleagues at the Colorado Department of Public Health and Environment complement each other to fight infections and protect patients. It's an honor to work with all these groups.

4. What do you wish senior leadership knew about infection control?

I wish they had a deeper understanding and appreciation of the increasing federal and state regulatory requirements that have impacted infection control during the past decade. I wish they had a deeper understanding and appreciation of the challenges placed upon the IP and will continue to be placed on them in the future.

5. What is your favorite and/or least favorite pathogen and why?

My least favorite pathogen is fungus because I have worked with the oncology population since graduate school and fungi are very devastating to this population of patients. It is very hard to deal with. You could have done everything right to prevent an infection and yet a patient still got this type of infection and died.

My favorite pathogen is *Bacillus* because of the outbreak investigation we completed which uncovered an issue that was deeper and more widespread than at one facility or manufacturer. Hopefully, the investigation will be a catalyst for changes and recommendations for sterile and non-sterile alcohol wipes.



Susan A. Dolan, RN, MS, CIC
Hospital Epidemiologist –
Children's Hospital
Colorado.

Susan has worked at Children's for 24 years and in Epidemiology/Infection Prevention and Control since 1994. Susan is married to Tom Dolan (25yrs), has two boys Jeff (22) and Josh (20), and resides in Littleton, CO. Susan grew up in Olean, New York, and is one of 10 children; Susan is #7. Susan moved to Colorado in 1987.

The HAI Hub's IP Champion is a peer nominated award, recognizing the remarkable work being conducted by the IP community throughout Colorado. There is no set list of requirements, experience level, or other qualifying factor.

If you are aware of an IP Champion, please consider nominating that individual for the spring edition of The HAI Hub. Please send the nominees name, place of employment, and a brief explanation of the qualities this IP embodies and why he/she should be your next IP Champion to Juan Suazo at: Juan.Suazo@dphe.state.co.us.

Dialysis Collaborative Update

The department's Patient Safety Program recently received federal funds from the CDC to implement an infection prevention collaborative with dialysis facilities.

The department has partnered with Intermountain End Stage Renal Disease Network to implement this collaborative, which has the goal of facilitating learning and sharing information, ideas and data to reduce dialysis related infections and spur a broader interest in preventing these infections among the dialysis community.

Prevention Collaborative members are representatives of outpatient dialysis facilities across Colorado who have pledged to work together through July 31, 2012. In doing so, participants will implement an intervention of their choice to improve hand hygiene, conduct observations of hand-hygiene opportunities, and assess and report compliance with CDC recommended practices to track progress in proper hand hygiene practice.

For more information please contact:

Tamara Hoxworth, PhD

Tamara.Hoxworth@state.co.us

NHSN Reporting—Case Studies

1) Hy Price, a former Wall Street broker, had a coronary artery bypass graft (CABG) with sternal wires on Jan. 14. Two weeks later he returned to the hospital and was diagnosed with a Methicillin-sensitive *Staphylococcus aureus* (MSSA) superficial incisional primary (SIP) infection. He was admitted for antibiotic therapy and discharged five days later. He seemed fine over the next two months until he returned to the emergency department with pain in his chest and a fever. He was diagnosed with a deep incisional primary (DIP) infection of his chest and the organism cultured was MSSA again.

1. Are both infections reportable? If not, what should the IP do?

2) Suzy Queue had a polyp removed from her colon on Feb. 2. On Feb. 4 she was re-opened to remove a retained sponge. The surgeon decided to swab the location near where the sponge was retrieved to be sure there was no accompanying infection. The culture grew rare yeast. It was not obtained from the colon itself.

2. Is this an Surgical Site Infection (SSI)? If so, what category and why?

3) Ten days following a Coronary Artery Bypass Graft with both donor and chest site incisions (CABG), John Snow develops a SSI in the pericardium and two days after this a SSI in the donor site, both with the same organism.

3. How many SSIs are reported and what are they?

4) Holly Jolly had the following procedures performed: a left partial mastectomy with ultrasound guided needle localization, sentinel lymph node mapping, excisional biopsy of lymph nodes, and right total mastectomy with axillary lymph node dissection/frozen section completed.

4. How many Denominator for Procedure forms are completed? What are the determining factors?

Answer Key to Case Studies

1. Per NHSN, only one infection, the more serious one – DIP – should be reported. The IP would remove the SIP and report the DIP infection.

2. Yes, depending on where the sponge was located, most likely DIP since colon was not involved when retrieving the sponge.

3. Two – pericardial infections are organ/space and the donor site is listed as a SIS.

4. Deciding factors: number of incisions and number of reportable procedures. In this case if there were two incisions, one for each breast and there was at least one reportable procedure for each breast, two DFP are completed for both mastectomy procedures. Needle localization, sentinel lymph node mapping, and excisional biopsy of lymph nodes are not reportable procedures. For breast procedure reporting there is a maximum of two procedures per patient per day that can be entered.

Long Term Care Facility HAI Surveillance Pilot Project

The department is beginning a new project with the CDC to pilot newly developed healthcare-associated infection (HAI) surveillance definitions, methods and tools designed specifically for long term care facilities (LTCFs). The purpose of this surveillance innovation project through the CDC's Emerging Infections Program (EIP) is to test and obtain feedback on the preliminary HAI surveillance tools before launching the LTCF component of NHSN.

Nursing homes and skilled nursing facilities will voluntarily participate in this project by participating in a surveillance module: urinary tract infections (UTIs) or laboratory identified *C.difficile* infections (CDI). A surveillance coordinator at each facility will then collect data for at least three and up to six consecutive months, and will be asked to complete an evaluation survey providing feedback on the time spent collecting data, NHSN education and training materials, and surveillance forms. This survey will give LTCFs the opportunity to offer suggestions to refine and improve HAI surveillance training materials and tools.

If you are interested in partnering with the department on this LTCF pilot project and providing critical feedback to improve HAI surveillance via NHSN, please contact Sarah Jackson (Sarah.Jackson@state.co.us) at (303) 692-3018.

NHSN Tip of the Month

A recurrent issue in NHSN involves the transfer of Facility Administrators (FA). In NHSN, a FA is not necessarily your facility or clinic manager. The role of NHSN FA may be assigned to any staff person, as long as s/he is a user of NHSN with a valid digital certificate. The person designated as FA is the only person who can enroll a facility in NHSN, complete facility surveys, add users, reassign the role of FA, and add or remove locations.

Challenges arise when an FA leaves his/her facility or job without reassigning the FA role to another user. Ideally, the FA will reassign the role in NHSN before s/he leaves. This is how to designate a new FA.

1. If the new FA is not already a user, add the person as a user by going into SDN (NHSN's Secure Data Network), NHSN Reporting. On the blue navigation bar, select users/add. At the Add Users page, enter the requested information into the required fields (denoted by red asterisks). Hit Save.
2. Make sure the "Administrator" box under Patient Safety is checked. Make sure you click the "Save" button.

Steps to reassign the NHSN FA

1. Make sure the user to be reassigned has administrative rights. To do so, go into SDN, NHSN Reporting. On the blue navigation bar, select users/find. Enter the user's first and last name and click the Find button to bring him/her up on the screen.
2. Select edit/edit rights. Make sure the "Administrator" box under Patient Safety is checked. Hit "Save".
3. Go to Facility/Contact information.
4. Next to the Contact box, where it says FADMIN-Facility Administrator, click the "Reassign" box
5. You'll be taken to a Find User screen, where you will click the "Find" box.
6. This will bring up a user list for you to select a user for reassignment.
7. Select user's name from the User List.
8. From the View User screen, click the Submit button below.
9. You'll be taken back to the facility Contact Information screen. Complete the empty required fields and click "Update."
10. You should get 2 messages, "The Facility Administrator Role has been reassigned" and "This organization has been successfully updated" with a checked box.

If the FA leaves before reassigning rights

You must fax or scan by email a letter to CDC on your facility's letterhead with a signature from your facility's executive/manager requesting that the position be reassigned. Be sure to provide the new FAs name, email address and phone number.

This letter should be faxed to Amber Craggette of the CDC's NHSN Help Desk at (404) 929-0131 or emailed to her at uyq2@cdc.gov.

Injection Safety Education, Awareness and Outreach

After a series of reported unsafe injection practices and breaches in infection control in healthcare facilities, the department, in collaboration with infection prevention, local public health departments, and other community partners, is working toward the promotion of injection safety education and awareness in Colorado. This group is committed to raise awareness and increase education about injection safety in Colorado.

Medical providers and staff responsible for administering vaccines should review safe injection practices and consult the department (303) 692-2700 with any questions or concerns. Patients are also encouraged to be well-informed advocates by recognizing unsafe practices and by talking with their healthcare provider about injection safety.

ONLY ONE. Only one needle, only one syringe, and only for you!

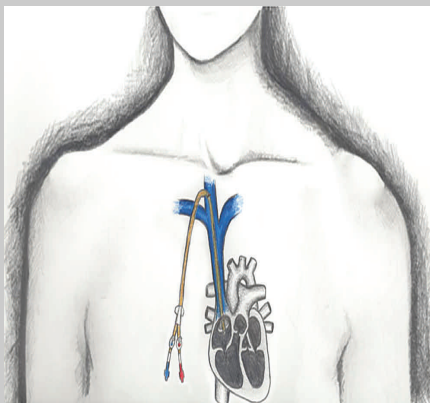
Additional resources for injection safety:

- ◆ One & Only Campaign: <http://www.oneandonlycampaign.org/>
- ◆ Centers for Disease Control and Prevention (CDC): <http://www.cdc.gov/injectionsafety/>

Questions and suggestions can be directed to Sarah Jackson (Sarah.Jackson@state.co.us) at (303) 692-3018.

Patient and Line Counting for CLABSI Data

All patients in an adult critical care unit, neonatal level II/III and III critical care units, and LTAC facilities regardless of status (e.g., critical care, observation, etc.) are counted in denominator patient days. All patients in these units with a central line are counted in denominator device days. In rare cases there may be patients with only a dialysis central line which neither the facility staff nor contractual staff access for a period of time. Most central lines require flushing at the very least once a day if no fluids are infused. However, since most IPs do not know when a staff person accesses a line for flushing, for example, it may be easier to include these lines in the daily device counts. Furthermore, by including the dialysis central lines, facility rates are more likely to be accurate and correctly reported.



Did you know...

...*Acinetobacter* infections seldom occur outside of healthcare settings in the U.S. Outbreaks of *Acinetobacter* infections usually take place in intensive care units and healthcare settings with very ill patients, such as those who are immunocompromised, ventilated, hospitalized for a prolonged period of time, or those who have invasive devices or open wounds. This organism presents very low risk to healthy people.

Acinetobacter was first described in 1911 as *Micrococcus calco-aceticus*. Since then, it has had several names, becoming known as *Acinetobacter* in the 1950s. This group of aerobic gram-negative bacilli, commonly found in soil and water, can cause a range of human diseases including pneumonia, blood and wound infections. Infections from this organism can either cause or contribute to death in patients.

Acinetobacter can also colonize patients, especially skin, wounds, and the respiratory tract, and risk factors for colonization include ICU stay, recent surgery, central vascular catheterization, tracheostomy, mechanical ventilation, enteral feedings, and treatment with third-generation cephalosporin, fluoroquinolone, or carbapenem antibiotics.

Of the 25 *Acinetobacter* species, *A. baumannii*, *A. calcoaceticus*, and *A. lwoffii* are most frequently reported in clinical literature. *A. baumannii* is usually multidrug-resistant, and accounts for about 80% of reported infections with *Acinetobacter*.

Since 1974, the CDC has noted higher rates of healthcare-acquired *Acinetobacter* infections in the summer than in other seasons. In environmental studies, warmer, humid ambient air has been shown to favor growth of this organism. Environmental contaminants of condensate from air-conditioning units have been implicated as a cause of *Acinetobacter* outbreaks.

Acinetobacter can be transmitted to at-risk patients by person-to-person contact or contact with contaminated surfaces. Outbreaks with this organism have been traced to common-source contamination, in particular contaminated respiratory-therapy and ventilator equipment, as well as transmission by the hands of healthcare workers. Since *Acinetobacter* can live on skin and can survive in the environment for several days, careful infection control practices, such as hand hygiene and environmental cleaning, can reduce the risk of transmission.

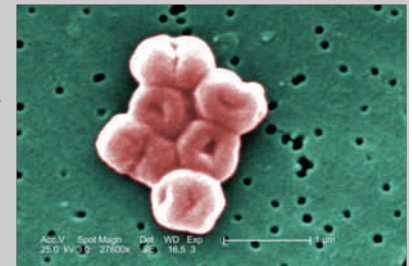
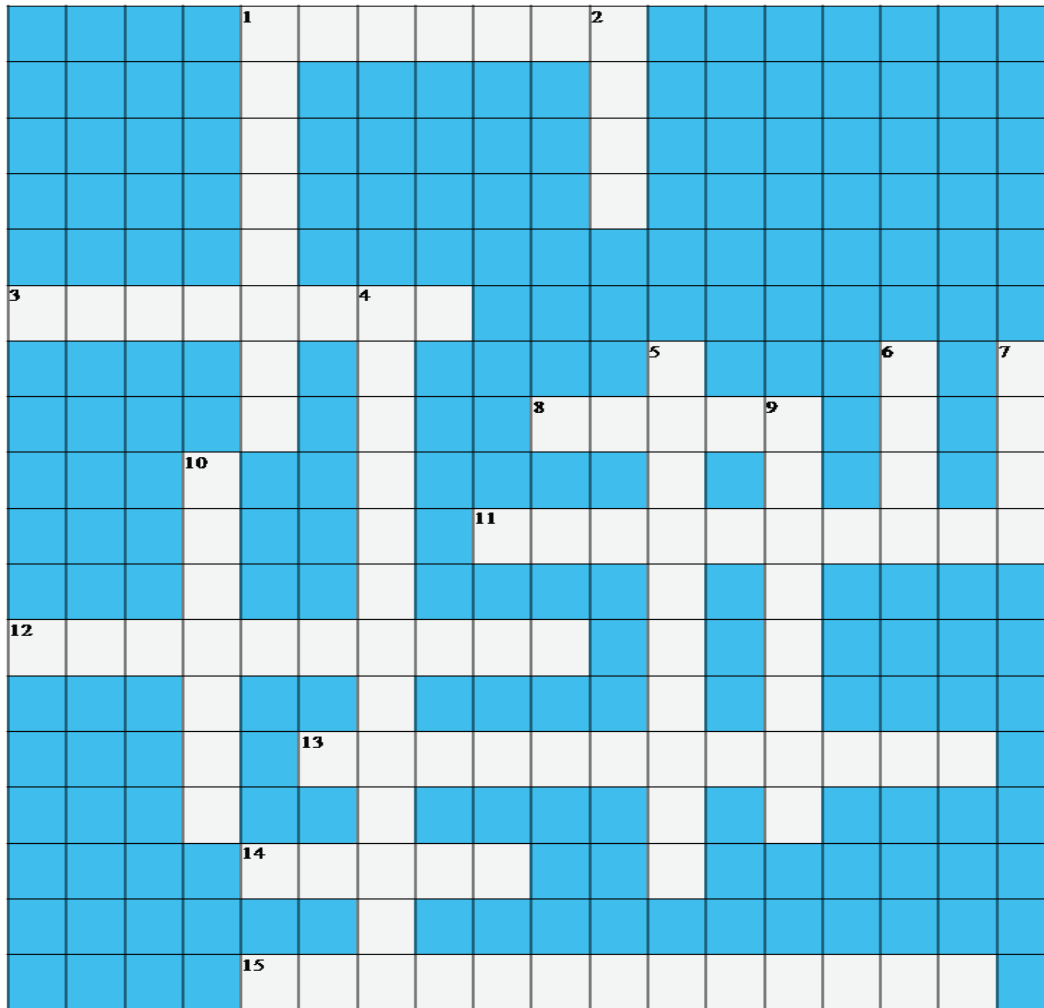


Photo Credit: Janice Haney Carr/CDC

Adapted from information obtained from:

- <http://www.cdc.gov/HAI/organisms/acinetobacter.html>
- <http://www.nejm.org/doi/full/10.1056/NEJMra070741>
- <http://emedicine.medscape.com/article/236891-overview>



The first person to complete the crossword puzzle correctly will receive a pre-purchased stuffed animal microbe from GIANTmicrobes.com

Print this page, fill out the puzzle, and either scan or fax to Juan Suazo at:


Juan.Suazo@dphe.state.co.us
Or
(303) 753-6214

DOWN

1. Ubiquitous one-celled organisms
2. Superbug resistant to many antibiotics
4. Capable of destroying or inhibiting the growth of disease-causing microorganisms
5. Something that prevents or slows the course of an illness or disease
6. A voluntary, secure, internet-based surveillance system that integrates and expands legacy patient and healthcare personnel safety surveillance systems managed by the Division of Healthcare Quality Promotion (DHQP) at CDC
7. A technique used for the separation of large deoxyribonucleic acid (DNA) molecules by applying an electric field that periodically changes direction to a gel matrix
9. Sara Reese's firstborn
10. In healthcare, the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge

ACROSS

1. A thin layer of microorganisms adhering to the surface of a structure, which may be organic or inorganic, together with the polymers that they secrete
3. A sudden rise in the incidence of a disease
8. An infective agent that typically consists of a nucleic acid molecule in a protein coat, is too small to be seen by light microscopy, and is able to multiply only within the living cells of a host
11. The total number of cases of the risk factor in the population at a given time, or the total number of cases in the population, divided by the number of individuals in the population
12. The prevention, treatment, and management of illness and the preservation of mental and physical well-being through the services offered by the medical and allied health professions
13. Contagious
14. A bacterium that causes diarrhea and more serious intestinal conditions such as colitis
15. Working together to achieve a goal

<p>Wendy Bamberg, MD Medical Epidemiologist for Healthcare-Associated Infections Wendy.Bamberg@state.co.us (303) 692-2491</p>	<p>Questions? Concerns? Feedback?</p>  <p>Please contact us!</p>	<p>Sara Reese, PhD Patient Safety Program Coordinator Patient Safety Program Sara.Reese@state.co.us (303) 692-2929</p>
<p>Communicable Disease Epidemiology Program DCEED-EPI-A3 4300 Cherry Creek Drive South Denver, Colorado 80246 (303) 692-2700</p>		<p>Patient Safety Program HFEMSD-A2 4300 Cherry Creek Drive South Denver, Colorado 80246 (303) 692-2800</p>

If you have any questions, comments or suggestions for *The HAI Hub*, please send your feedback to Juan Suazo at: Juan.Suazo@dphe.state.co.us