Infection Prevention Series 2018

All webinars have been recorded and are available at
https://www.youtube.com/playlist?list=PL5ITOxWOe7Jp6F6190m8hZJIPfqWyooMq
(Slides for each webinar are also available via a link in the narrative below the YouTube screen)

Surveillance & Antibiotic Stewardship

Q: I am interested if you group all the antibiotic cases in one section and group (fungal, dermatologicals, etc.) in the monthly report? Do you even track your antifungals used? I have heard of leaving those out, which I am opposed to.

It is helpful to group your antibiotics together by class/family of antibiotics (such as fluoroquinolones) to give you a better idea of your usage patterns and potential overuse of a class of antibiotics. Most facilities do not include antifungals. You may want include them it if you feel you have an issue with inappropriate use or overuse.

Q: I need link for a Facility IP Risk Assessment.

Centers for Disease Control and Prevention (CDC) has an example on their website: https://www.cdc.gov/infectioncontrol/pdf/icar/ltcf.pdf in a word format.

Q: Is it still acceptable to assume that the percentages listed within the Antibiogram – Should the sensitivities still be above 80% to be efficacious. Therefore, under 80% would not be a wise choice of that particular antibiotics?

It is not quite that simple. It depends on several factors including whether your laboratory is reporting all antibiotics tested or not reporting those that should not be used for that organism/culture type. I would suggest working with your laboratory and your pharmacist to evaluate your particular Antibiogram.

Q: We are seeing a lot of antibiotic starts for COPD exacerbations, as well as pneumonia, and provider refuses to order chest x-rays. Do we have to be logging these antibiotic starts as HAI in our facility? Would like the link or information that provides the definition for this.

McGeer criteria should be used to determine if all criteria were met to define as a healthcare associated infection. (HAI)
http://www.fadona.org/2017/116%20Surveillance%20Definitions%20of%20Infections%20in%20Long-Term%20Care%20Facilities.pdf

Q: Can you share the surveillance tool you mentioned?

Here is the log I mentioned: https://www.lsqin.org/initiatives/nursing-home-quality/essentials/
Also, click on Infection and Antibiotic Use Tracking. You may also want to consult your state Division of Public Health, as they may also have an example for you.

Q: Is an infection rate of 7.0/per 1000 Elder days an acceptable level? This is among all infections across the board for the month. I can find no literature to support that 7.0 incidence per 1000 Elder days is acceptable.

When you combine all infection types, from Urinary Tract Infection (UTI) to Conjunctivitis, for a rate, it is nearly impossible to benchmark with other facilities. It is also difficult to evaluate the significance of that value or of an increase because of the differences in each infection type. It is more helpful to separate your infection types and compare your facility data over time. For example, you may want to calculate a rate for UTI, Respiratory, Gastrointestinal Illness, and other infections you track. Benchmark infection data for long term care is not as plentiful as for acute care, but as more facilities report data into NHSN, it is increasing.

Q: Can you review how to calculate an infection rate again?

Infection rate is calculated by the following formula

$$\frac{\text{\# of infections}}{\text{Population at risk}} \times \text{Constant} = \text{rate}$$

- Determine the number of infections
- Determine the population at risk , for example, for Gastrointestinal Illness it is all residents, for Catheter Associated Urinary Tract Infections (CAUTI) it is only those with urinary catheter
- The constant used is determined by volume of events, and makes the calculation consistent so that facilities can compare data with other facilities.
    - For *C. difficile* infection, the constant used is /10,000 resident days
    - For CAUTI, the constant used is 1000

Q: Do you find it easier to infection/illness on the same spreadsheet as the antibiotic use or should it be separate?

It is personal preference and seems to be split quite evenly among the call participants today.

Q: Can you tell me where to find the specific infection worksheets?

Your state Division of Public Health:

- Here is an example of a Wisconsin UTI worksheet: https://www.dhs.wisconsin.gov/regulations/nh/uti-ltc-worksheets.pdf
- Here is an example of a Wisconsin MDRO/CDI worksheet: https://www.dhs.wisconsin.gov/files/ltcfmdrocdiff.pdf

Q: Is there a good reference to use to decide if the antibiotic was appropriate?

I would start with McGeer's criteria, does it meet the definition of an infection? What were the signs and symptoms exhibited by the resident? Your Antibiotic Stewardship Committee & Medical Director should also be involved in determination of appropriateness.

Q: Is there anywhere to find a list that staff could use to know when they need to contact the Infection Preventionist?

It is somewhat dependent on your facility, what does your risk assessment show? Outbreak identification, reportable communicable diseases etc. should be included.

Q: Should the IP be auditing other departments like dietary, housekeeping, beauty shop and therapy? Or should the dept. head do this?

The IP is ultimately responsible for the entire facility, but it is very helpful to work collaboratively with the department head when doing audits.

Q: Can you provide a sample antibiotic use tracking sheet?

Type in Internet search box - https://search.ahrq.gov/search (put antibiotic tracking sheet in AHRQ search box)

Q: Do you track thrush or candida?

Optional depending on frequency in your facility. Many facilities would include in "other" category.

Q: When a resident is diagnosed with a UTI with an Extended-Spectrum Beta-lactamase (ESBL), should we be re-culturing prior to discontinuing transmission based precautions?

No, re-culturing is not indicated unless resident still has symptoms after completion of treatment which may indicate treatment failure.

Q: I am reviewing a case for a possible UTI, if the resident does not meet all required criteria, should I still count it?

If the case does not meet the required elements of the criteria, it would not be counted as a UTI.

Q: What is the best way to display your data?

Compiling your data on an excel worksheet and then making a run chart is the most common way to display your data. Run Charts can show change over time. If your facility has data tracking and report generating software, it can also be used.

Q: Is there an Infection Prevention risk assessment we can use?

https://www.cdc.gov/infectioncontrol/pdf/icar/ltcf.pdf

Another example of an Infection Prevention Risk Assessment that prioritizes need:
http://eo2.commpartners.com/users/apic/downloads/Sample_Infection_Prevention_Risk_Assessment.pdf

Outbreak Management

Q: Who do I notify of possible outbreak if the Local Health Department (LHD) is not open? (After hours, weekends, holidays)

If your LHD does not have a 24 hour contact phone number, contact your state Health Department.

Q: Should my facility have protocol for automatic prophylaxis with Tamiflu for Influenza outbreak?

If your facility has developed a standing order for prophylaxis with involvement of your medical director, be aware of:

- Need to identify who to notify – resident representative, family, provider, etc.
- Need to evaluate renal function (Serum Creatinine or Creatinine Clearance)

Q: What additional measures do you put in place during outbreak?

Successful strategies for dealing with outbreaks shared by call participants:

- Letters to family
- Signage at entrances
- Masks and alcohol hand gel at entrances
- Encourage visitors to not visit – encourage visitors to wear mask if they have a cough
- Encourage cough etiquette and hand hygiene
- Standing order for Tamiflu once Influenza is confirmed (consider Kidney function of residents)
    - Family of resident should be aware of this practice, put into education packet
- Consider building in transmission based precautions
- Gown and gloves for all cares
- Hand sanitizer in lobby as well as entrance
- Provide Influenza vaccination for new residents for as long as you have vaccine in facility
- Housekeeping increases frequency of cleaning of common areas to 4 times daily
- Refresher in-service for staff, hand hygiene, transmission-based precautions, policy etc.
- Keep very good track of dates, numbers of residents and staff, and actions taken for health department report
- Posted visitor restrictions on our webpage and social media as well as letters to family and volunteers
- Updated staff via daily email

Q: Does your facility require mandatory masking policies during Influenza season?

Responses from participants include:

- Require staff who have not received the immunization to stay home during outbreak
- Require staff to mask if they have cough, ill, cold symptoms and have not received the immunization
- Mandatory masking for those without vaccination if within 3 feet of resident
- Mandatory masking for those who did not receive the vaccination during entire Influenza season, not just during outbreak
- Mandatory masking when staff (who have not received vaccination) is within 6 feet of any resident
- Reminder that masks are a disposable item, meant to be used once and discarded as you leave the resident room. **One mask – One patient** slogan used in training. Facility also has a policy of no masks in hallways.

Q: How do you provide Contact Precautions to all residents in the event of a norovirus outbreak within the entire facility?

Risk assessment should be done to decide how to handle group activities and meals etc. Staff should be reminded that they still need to utilize Personal Protective Equipment with each resident care, (even if all residents are ill, the process also is important to keep staff from becoming ill)

Q: I was surprised by the IDSA *C difficile* recommendations that were just released and their comments related to soap and water or alcohol gel for hand hygiene. Should we be changing what we teach our staff?

Infectious Diseases Society of America (IDSA) released their "Clinical Practice Guidelines for *Clostridium difficile* Infection in Adults and Children in February 2018.

XVII. What is recommended hand hygiene method (assuming glove use) when caring for patients in isolation for CDI?

1. In routine or endemic settings, perform hand hygiene before and after contact of a patient with CDI and after removing gloves with either soap and water or an alcohol–based hand hygiene product (strong recommendation, moderate quality of evidence)
2. In CDI outbreaks or hyperendemic (sustained high rates) settings, perform hand hygiene with soap and water preferentially instead of alcohol- based hand hygiene products before and after caring for a patient with CDI given the increased efficacy of spore removal with soap and water (weak recommendation, low quality of evidence).
3. Handwashing with soap and water is preferred if there is direct contact with feces or an area where fecal contamination is likely (e.g. The perineal region) (good practice recommendation)

There has been a lot of discussion in the Infection Prevention and Control community since the release of these guidelines. There is variation in guidelines and protocols.

Questions frequently arise in regards to the recommended method of hand hygiene after caring for patients with Clostridium difficile infection (CDI). The CDI component of the SHEA / IDSA Compendium of Practice Recommendations to Prevent Healthcare- Associated Infections and the SHEA / IDSA Clinical Practice Guidelines for CDI recommend preferential use of soap and water for hand hygiene over alcohol-based hand hygiene products only in outbreak settings (A weak recommendation supported by any quality evidence)

In summary, I would say that there is need for more study to resolve this issue. In the meantime, how can you make it easy for your staff to perform hand hygiene as indicated?

Transmission-based Precautions (TBP)

Q: When a resident has been in Contact Precautions, should supplies be thrown away upon discontinuation of isolation?

An assessment should be done of the likelihood that supplies have become contaminated.

Q: How often should disposable masks be changed?

Masks are a disposable, one time use item, so it should be thrown away as you exit a resident's room. If you are providing care in a resident's room for an extended period of time, it should be discarded if it becomes

damp from exhaled breath. (General rule is 2 hours) A mask should never be worn in the hall or when going from room to room.

Q: One challenge I have is cognitively impaired residents who require precautions or isolation, keeping them in isolation or in compliance with precautions is not always easy.

Cognitively impaired residents may require more staff supervision and assistance in performing hand hygiene etc. It is a delicate balance between preventing transmission and not restricting resident movement.

Q: If a resident is *C. difficile* positive, do we need precautions all the time or just when providing care such as changing the ileostomy bag?

The CDC Type and Duration of Precautions Recommended for Selected Infections and Conditions states "Duration of Illness" for *C. difficile* Infection. If the resident is still symptomatic, Contact Precautions should be in place.

Q: What Transmission-based precautions (TBP) are indicated for RSV?

The CDC Type and Duration of Precautions Recommended for Selected Infections and Conditions states Contact and Standard. In the case of respiratory illness, Standard includes use of mask. (You may call this Contact and Droplet)

Q: What information can be placed on the sign posted on resident's door?

The type of TBP can be on the sign but not the reason for the precautions (the sign should say Contact Precautions, but not *C difficile*). It is helpful to have pictures of the Personal Protective Equipment that staff is expected to wear.

Q: What is included in the clinical assessment of resident to determine if TBP are indicated?

Start with the 3 –C's

- Contained – Are all secretions and body fluids be contained?
- Cognitive/Cooperative – Is resident able to understand directions and follow those directions related to hand hygiene, respiratory etiquette etc.?
- Clean – What is status of resident's personal hygiene?

Document this assessment in resident care plan.

Q: What is the difference between colonization and infection?

Colonization is the presence of organism without illness (no signs and symptoms).
Infection is the presence of illness (signs and symptoms) caused by that organism. Other than perhaps for very few organism such as CRE, TBP are not indicated for colonization.

Q: Would you place a resident in TBP if they are symptomatic but testing is not back yet?

Yes, if infection is suspected, and residents has signs and symptoms of infection, TBP should be initiated immediately and not wait for test results.

Q: If a resident is asymptomatic but still on treatment, can TBP be discontinued?

Yes, in most cases, once the resident is asymptomatic, TBP can be discontinued as long as you have considered the residents hygiene and cognitive abilities. ***Be sure to follow specific state guidelines for organisms such as CRE.

Q: With a resident colonized with a MDRO, should Contact precautions be utilized when performing cares, such as straight catheterization, due to risk of splashing of body fluid?

Appropriate Personal Protective Equipment (PPE) should always be used when there is risk of splash or spray of body fluid, this is part of standard or universal precautions. Indicated PPE may include, gloves, gowns, and protection of all mucous membranes including eyes, nose, and mouth.

Q: What about the resident with shingles, we do not fit test our employees with N-95 respirators?

Refer to the CDC "Type and Duration of Precautions Recommended for Selected Infections and Conditions". Are the lesions dried and crusted? Can all lesions be covered (contained)? If not, work with your local health department to determine if the resident can stay in your facility and what precautions to take during transfer if transfer is indicated.

Q: Does a resident with *C difficile* who also has a chronic condition such as Irritable Bowel Syndrome need to continue TBP?

You need to consider what the resident's baseline is, once they return to their baseline stooling pattern, then follow the 3 –C's

- Contained – Can all secretions and body fluids be contained?
- Cognitive/Cooperative – Is resident able to understand directions and follow those directions related to hand hygiene, respiratory etiquette etc.?
- Clean – What is status of resident's personal hygiene?

Document this assessment in resident care plan.

Q: Why is it not necessary to wear a gown when caring for resident on Droplet Precautions?

Refer to your state guidance – an example from Wisconsin's "Reporting, prevention and control of acute respiratory illness outbreaks in long-term care facilities":

4.1 Droplet Precautions are intended to prevent transmission of pathogens spread through close respiratory or mucous membrane contact with respiratory secretions. In contrast to contact transmission, respiratory droplets carry and transmit infectious pathogens when they travel directly from the respiratory tract of the infectious individual to susceptible mucosal surfaces of the recipient, generally over short distances.

4.1.1 Health care personnel should wear a mask (a respirator is not necessary) for close contact with an ill resident. The mask is generally donned immediately prior to room entry.

4.1.2 Residents on droplet precautions who must be transported outside of their room should wear a mask if tolerated and practice respiratory hygiene/cough etiquette.

4.2 Contact Precautions apply when the presence of discharges from the body suggest an increased potential for extensive environmental contamination and risk of transmission.

4.2.1 Health care staff should wear a gown and gloves for all interactions that may involve direct contact with the resident or potentially contaminated areas in the environment.

Q: With our transitional care unit, we are seeing an increase of admissions with recent history of *C. difficile.* When resident is no longer having loose stools, and not currently on treatment, is Contact Precautions needed when toileting resident?

If resident is no longer symptomatic, TBP are not indicated.

Q: We have a resident with a wound infection with MRSA. Wound drainage is contained by dressing. We are doing dressing changes with gown and gloves. Are Contact Precautions indicated for this resident?

Refer to the CDC "Type and Duration of Precautions Recommended for Selected Infections and Conditions". MDROs judged by the infection control program, based on local, state, regional, or national recommendations, to be of clinical and epidemiologic significance. Contact Precautions recommended in settings with evidence of ongoing transmission, acute care settings with increased risk for transmission or wounds that cannot be contained by dressings

Assessment:

- Wound drainage is contained by dressing (not soaking through and contaminating bedding, or environment)
- Staff are wearing gown and gloves when doing dressing changes (if risk of splash or spray, also protect mucous membranes with faceshield). Barriers should also be used to prevent contamination of bedding and environment during dressing changes.
- TBP are not indicated

Q: We have a resident colonized with ESBL in urine. She is incontinent of urine. She has no signs of symptoms of infection. Staff are using gowns when changing her briefs. Is this necessary?

As part of Standard Precautions, since the resident is incontinent of urine, you must assess the risk of contamination of staff uniforms and the resident environment. If there is risk of contamination, gowns would be indicated.

State survey - Frequent citations

Q: What level of citation is most common for Infection Prevention?

Infection Prevention and Control citations typically do not reach Immediate Jeopardy (IJ) level. It will vary depending on what deficiency is found, how frequent it is and what harm was caused or could potentially be caused. Refer to the Infection Prevention and Control Critical Element Pathway – May 20, 2017 http://cmscompliancegroup.com/2017/08/29/ltc-survey-pathways-entrance-form/

Q: How often do glucometers need to be disinfected if every resident has their own individual glucometer?

Refer to the manufacturer's directions for product to be used and time required for disinfection. The manufacture of that piece of equipment is required to give you required information on frequency, product used etc. Another reference would be documents on CDC website as well as your state Division of Public Health.

Q: Are state surveyors asking to see the audits for compliance we are doing?

They may ask to see them, especially if they observe non-compliance during their stay.

Training for Infection Prevention & Control

Q: Will I have to be certified by the Association for Professionals in Infection Control & Epidemiology (APIC) in order to work as an Infection Preventionist in long term care?

No, there is currently no requirement to be APIC certified. The CMS memo states that completion of the online course which will be released in spring of 2019 will provide a certificate of completion.

Q: When will the CMS certificate training be available?

CMS and CDC are collaborating on the development of a training course in Infection Prevention & Control that is slated for release in spring of 2019. This course will be free of charge, online, and available on demand.

Miscellaneous

Q: Is there information or resources on safe food handling to teach the aides, when they are serving the food trays?

Training materials for Certified Nursing Assistants may be purchased from a Madison College Bookstore. There is also a FREE PDF version of the book available (please click link).

Q: Do you know what the strength of heavy duty gloves should be when sorting out dirty laundry in the laundry department?

Wisconsin State manual does not indicate gauge of heavy duty utility gloves.

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